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The Iowa Administrative Code Supplement is published biweekly pursuant to Iowa Code section 17A.6. The Supplement contains replacement chapters to be inserted in the loose-leaf Iowa Administrative Code (IAC) according to instructions included with each Supplement. The replacement chapters incorporate rule changes which have been adopted by the agencies and filed with the Administrative Rules Coordinator as provided in Iowa Code sections 7.17 and 17A.4 to 17A.6. To determine the specific changes in the rules, refer to the Iowa Administrative Bulletin bearing the same publication date.

In addition to the changes adopted by agencies, the replacement chapters may reflect objection to a rule or a portion of a rule filed by the Administrative Rules Review Committee (ARRC), the Governor, or the Attorney General pursuant to Iowa Code section 17A.4(6); an effective date delay imposed by the ARRC pursuant to section 17A.4(7) or 17A.8(9); rescission of a rule by the Governor pursuant to section 17A.4(8); or nullification of a rule by the General Assembly pursuant to Article III, section 40, of the Constitution of the State of Iowa.

The Supplement may also contain replacement pages for the IAC Index or the Uniform Rules on Agency Procedure.

INSTRUCTIONS

FOR UPDATING THE

IOWA ADMINISTRATIVE CODE

Agency names and numbers in bold below correspond to the divider tabs in the IAC binders. New and replacement chapters included in this Supplement are listed below. Carefully remove and insert chapters accordingly.

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CHAPTER 85
REGULATION OF NAVIGATORS

191—85.1(505,522D) Purpose and authority.

85.1(1) The purpose of these rules is to set out the requirements, procedures and fees relating to the qualification, licensure, training, continuing education and regulation of navigators.

85.1(2) These rules are established based upon the authority provided in Iowa Code sections 505.8(19) and 522D.10.

[ARC 0981C, IAB 8/21/13, effective 9/25/13]

191—85.2(505,522D) Definitions. As used in this chapter:

“*ACA*” means, collectively, the Patient Protection and Affordable Care Act (Pub. L. 111-148) and Health Care and Education Reconciliation Act (Pub. L. 111-152).

“*Applicant*” means an individual or entity applying or intending to apply for a navigator license.

“*Business entity*” means a corporation, association, partnership, limited liability company, limited liability partnership or other legal entity.

“*Commissioner*” means the Iowa commissioner of insurance.

“*Credit*” means continuing education credit. One credit is 50 minutes of instruction or reading material in an acceptable topic.

“*Division*” means the Iowa insurance division.

“*Health insurance*” means insurance that is primarily for the diagnosis, cure, mitigation, treatment, or prevention of disease or amounts paid for the purpose of affecting any structure of the body, including transportation that is essential to obtaining medical care, but excluding:

1. Coverage only for accident or disability income insurance, or any combination thereof;
2. Coverage issued as a supplement to liability insurance;
3. Liability insurance, including general liability insurance and automobile liability insurance;
4. Workers’ compensation or similar insurance;
5. Automobile medical payment insurance;
6. Credit-only insurance;
7. Coverage for on-site medical clinics;
8. Coverage only for limited-scope vision benefits;
9. Benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof;
10. Coverage for specified disease or critical illness;
11. Hospital indemnity or other fixed indemnity insurance;
12. Medicare supplement policies;
13. Medicare, Medicaid, or the Federal Employee Health Benefit Program, 5 U.S.C. §§ 8901 - 8914, as it existed on January 1, 2013;
14. Coverage only for medical and surgical outpatient benefits;
15. Excess or stop-loss insurance; and
16. Other similar insurance coverage under which benefits for health insurance are secondary or incidental to other insurance benefits.

“*Individual*” means a private or natural person, as distinguished from a partnership, corporation or association.

“*License*” means the authorization by the commissioner for a person to act as a navigator in the state of Iowa.

“*Marketplace*” means any health benefit exchange authorized under the ACA and established or operating in this state, including any exchange established or operated by the U.S. Department of Health and Human Services.

“*Navigator*” means the individual or business entity that is granted the title, duties, and responsibilities under 45 CFR § 155.210 of a navigator by the granting or appointing authority. A

navigator would engage in the activities and meet the standards described in 45 CFR § 155.210, including:

1. Maintaining expertise in eligibility, enrollment, and program specification;
2. Conducting public education activities to raise awareness about the marketplace;
3. Providing information and services in a fair, accurate, and impartial manner, including information that acknowledges other health programs such as Medicaid and the healthy and well kids in Iowa program;
4. Facilitating selection of a qualified health plan;
5. Providing referrals for consumers with questions, complaints, or grievances to any applicable office of health insurance consumer assistance or health insurance ombudsman established under Section 2793 of the Public Health Service Act, or other appropriate state agency or agencies;
6. Providing information in a culturally and linguistically appropriate manner, including to persons with limited English proficiency; and
7. Ensuring accessibility and usability of navigator tools and functions for persons with disabilities.

“Navigator renewal notice” means a written or electronic communication issued by the division to inform a navigator about license renewal.

“Negotiate” means the act of advising a purchaser or prospective purchaser of a particular contract of insurance concerning any of the substantive benefits, terms or conditions of the contract provided that the person engaged in that act either sells insurance or obtains insurance for purchasers. The definition of “negotiate” shall not include:

1. Impartially informing a purchaser or prospective purchaser about substantive benefits, terms or conditions of a contract while facilitating the enrollment in a qualified health plan by providing fair, impartial, and accurate information that assists a purchaser or prospective purchaser with submitting an eligibility application;
2. Clarifying the distinctions among qualified health plans; and
3. Helping qualified individuals make informed decisions during a health plan selection process.

“Person” means an individual or entity.

“Producer” means a person required to be licensed in this state to sell, solicit or negotiate insurance.

“Qualified health plan” means a health benefit plan that has in effect a certification that the plan meets the criteria for certification described in Section 1311(c) of the ACA.

“Sell” means to exchange a contract of insurance by any means, for money or its equivalent, on behalf of an insurer.

“Solicit” means attempting to sell insurance or asking or urging a person to apply for a particular kind of insurance from a particular company.

“U.S. Department of Health and Human Services” means the United States Department of Health and Human Services and any of its subsidiaries.

[ARC 0981C, IAB 8/21/13, effective 9/25/13]

191—85.3(505,522D) Requirement to hold a license. No person may act as a navigator in Iowa until that person has been issued an Iowa navigator license.

85.3(1) To be licensed as a navigator, a person must satisfy the following requirements:

- a. Be at least 18 years of age;
- b. Demonstrate compliance with the initial training and certification requirements set forth in rule 191—85.10(505,522D);
- c. Have not committed any act that is grounds for denial, suspension or revocation under Iowa Code section 522D.7;
- d. Submit a completed uniform application;
- e. Pass an examination on the duties and responsibilities of a navigator and the insurance laws and regulations of Iowa with a score of 70 percent or higher;
- f. Pay the nonrefundable navigator license fee of \$20; and
- g. Pass a background check or security screening.

85.3(2) The division may require any documents reasonably necessary to verify the information or attestations contained in the application or to verify that the applicant has the character and competency required to receive a navigator license. If an applicant does not provide the additional information requested by the division within 45 days of receipt of the request, the application will expire and the license fee will not be returned.

85.3(3) Except for producers licensed in Iowa, a person acting as a navigator without an Iowa navigator license or a person performing the enrollment duties of a navigator without an appointment, certification, or a grant to perform such duties by the U.S. Department of Health and Human Services shall be in violation of this chapter.

a. Upon the determination by the commissioner that a person is in violation of this chapter, the commissioner may issue a summary order directing the person to cease and desist from engaging in the act or practice in violation of this chapter. A person that has been issued a summary order under this rule may contest the order by filing a request for a contested case proceeding and hearing as provided in Iowa Code chapter 17A.

b. The person shall have at least 30 days from the date that the order is issued in order to file the request. The order shall remain effective from the date of issue unless overturned by a presiding officer of the court following a request for a hearing. If a hearing is not timely requested, the summary order becomes final by operation of law.

c. A person violating a summary order issued under this rule shall be deemed in contempt of that order. The commissioner may petition the district court to enforce the order as certified by the commissioner. The district court shall adjudge the person in contempt of the order if the court finds after hearing that the person is not in compliance with the order. The court may assess a civil penalty against the person and may issue further orders as it deems appropriate.

[ARC 0981C, IAB 8/21/13, effective 9/25/13]

191—85.4(505,522D) Issuance of license.

85.4(1) A person that meets the requirements of this chapter and of Iowa Code sections 522D.4 and 522D.5, unless otherwise denied licensure pursuant to Iowa Code section 522D.7, shall be issued a navigator license. A navigator license shall be valid for three years. A navigator license remains in effect unless revoked or suspended as long as all required fees are paid and continuing education requirements are met. A renewal term is three years. If not renewed, a navigator license automatically terminates on the last day of the month of the initial or renewal term.

85.4(2) An individual navigator whose license has expired may seek reinstatement as set forth in rule 191—85.6(505,522D).

85.4(3) The license shall contain the navigator's name and address, the date of issuance, the date of expiration and any other information the division deems necessary.

85.4(4) If the division issues or renews a navigator license and subsequently determines that payment for the license or renewal was returned without payment to the division by a bank, or that the credit card company does not approve or cancels or refuses amounts charged to the credit card, the license shall be immediately suspended until the payments are made and any fees or penalties charged by the division are paid, at which time the license may be reinstated. The individual may request a hearing within 30 days of receipt of notice by the division that the license was suspended.

[ARC 0981C, IAB 8/21/13, effective 9/25/13]

191—85.5(505,522D) License renewal. A navigator must apply for license renewal within 60 days prior to the expiration date of the license. Failure to apply to renew a license and pay appropriate fees prior to the expiration date of the license will result in expiration of the license.

[ARC 0981C, IAB 8/21/13, effective 9/25/13]

191—85.6(505,522D) License reinstatement.

85.6(1) A navigator may reinstate an expired license up to 12 months after the license expiration date by proving that during the continuing education term the navigator met the continuing education requirements of this chapter and by paying a reinstatement fee and license renewal fees. A navigator

that fails to apply for license reinstatement within 12 months of the license expiration date must apply for a new license.

85.6(2) A navigator that has surrendered a license for a nondisciplinary reason and stated an intent to exit the insurance business may file a request to reactivate the license. The request must be received at the division within 90 days of the date the license was placed on inactive status. The request will be granted if the former navigator is otherwise eligible to receive the license. If the request is not received within 90 days, the navigator must apply for a new license.

[ARC 0981C, IAB 8/21/13, effective 9/25/13]

191—85.7(505,522D) Reinstatement or reissuance of a license after suspension, revocation or forfeiture in connection with disciplinary matters; and forfeiture in lieu of compliance.

85.7(1) The term “reinstatement” as used in this rule means the reinstatement of a suspended license. The term “reissuance” as used in this rule means the issuance of a new license following either the revocation of a license or the forfeiture of a license in connection with a disciplinary matter. This rule does not apply to the reinstatement of an expired license.

85.7(2) Any navigator whose license has been revoked or suspended by order, or that forfeited a license in connection with a disciplinary matter, may apply to the commissioner for reinstatement or reissuance in accordance with the terms of the order of revocation or suspension or the order accepting the forfeiture.

a. All proceedings for reinstatement or reissuance shall be initiated by the applicant. The applicant shall file with the commissioner an application for reinstatement or reissuance of a license.

b. An application for reinstatement or reissuance shall allege facts which, if established, will be sufficient to enable the commissioner to determine that the basis of revocation, suspension or forfeiture of the applicant’s license no longer exists and that it will be in the public interest for the application to be granted. The burden of proof to establish such facts shall be on the applicant.

c. A navigator may request reinstatement of a suspended license prior to the end of the suspension term.

d. Unless otherwise provided by law, if the order of revocation or suspension did not establish terms upon which reinstatement or reissuance may occur, or if the license was forfeited, an initial application for reinstatement or reissuance may not be made until at least one year has elapsed from the date of the order of the suspension, revocation, or acceptance of the forfeiture of a license.

85.7(3) All proceedings upon the application for reinstatement or reissuance, including matters preliminary and ancillary thereto, shall be held in accordance with Iowa Code chapter 17A. Such application shall be recorded in the original case in which the original license was suspended, revoked, or forfeited, if a case exists.

85.7(4) An order of reinstatement or reissuance shall be based upon a written decision which incorporates findings of fact and conclusions of law. An order granting an application for reinstatement or reissuance may impose such terms and conditions as the commissioner or the commissioner’s designee deems desirable. The order shall be a public record, available to the public, and may be disseminated in accordance with Iowa Code chapter 22.

85.7(5) A request for voluntary forfeiture of a license shall be made in writing to the commissioner. Forfeiture of a license is effective upon submission of the request unless a contested case proceeding is pending at the time the request is submitted. If a contested case proceeding is pending at the time of the request, the forfeiture becomes effective when and upon such conditions as required by order of the commissioner. A forfeiture made during the pendency of a contested case proceeding is considered disciplinary action and shall be published in the same manner as is applicable to any other form of disciplinary order.

85.7(6) When a navigator’s license has been suspended for a period of time which extends beyond the navigator’s license expiration date, the license will terminate. The navigator may request reinstatement pursuant to this rule. If suspension for a period of time ends prior to the navigator’s license expiration date, the division shall reinstate the license at the end of the suspension period. The commissioner is

not prohibited from bringing an additional immediate action if the navigator has engaged in misconduct during the period of suspension.

[ARC 0981C, IAB 8/21/13, effective 9/25/13]

191—85.8(505,522D) Change in name, address or state of residence.

85.8(1) If a navigator changes the navigator's legal name, the navigator must file written notification with the division within 30 days of the name change. The notification must include the navigator's previous name and new name.

85.8(2) If a navigator changes the navigator's address, the navigator must file written notification with the division within 30 days of the address change. The notification must include the navigator's name, previous address, and new address. A navigator may designate a business address instead of a residential address at the option of the navigator.

85.8(3) If a navigator has provided an e-mail address to the division, the division has the option to send information to the navigator through the e-mail address rather than through the mail.

[ARC 0981C, IAB 8/21/13, effective 9/25/13]

191—85.9(505,522D) Licensing of a business entity.

85.9(1) A business entity that has been appointed as a navigator shall obtain a navigator license.

85.9(2) Navigator entities shall be exempt from the requirements of training, examination, and continuing education. All individual navigators that are hired, retained, recruited, employed, affiliated, work for or in conjunction, or as a part of a consortium, with a navigator entity shall be subject to all training, examination, and continuing education requirements under this chapter.

85.9(3) Navigator entities shall be liable for the acts of individual navigators that are hired, retained, recruited, employed, affiliated, work for or in conjunction, or as a part of a consortium, with a navigator entity when the individual navigator is performing the duties of or acting as a navigator.

85.9(4) A navigator entity shall notify the division in writing, within 30 days, when a relationship is terminated with an individual navigator who was formally retained, employed, or affiliated with, or worked for or in conjunction, or as a part of a consortium, with that navigator entity. The notification submitted by the navigator entity shall indicate if the termination was for cause and if the reason was one of the reasons set forth in Iowa Code section 522D.7. The navigator entity shall comply with Iowa Code section 522D.8 and, upon request, furnish to the commissioner or authorized representative additional information, documents, records or other data pertaining to the termination or activity of the individual navigator.

[ARC 0981C, IAB 8/21/13, effective 9/25/13; ARC 1710C, IAB 10/29/14, effective 12/3/14]

191—85.10(505,522D) Initial training of navigators.

85.10(1) Individual navigators shall complete a minimum of 32 credits of initial training in courses approved by the commissioner. Initial training must include a minimum of 2 credits of Iowa-specific training on Medicaid and healthy and well kids in Iowa program training, as well as a minimum of 1 credit in the subject of ethics. Navigators shall be responsible for obtaining their own training. An individual navigator may apply for waiver of this requirement should training not be accessible at the level required.

85.10(2) Courses provided by the federal government or approved by the federal government on ACA-related topics will be considered approved by the commissioner.

85.10(3) Individual navigators shall complete all training and certification requirements provided by the U.S. Department of Health and Human Services.

[ARC 0981C, IAB 8/21/13, effective 9/25/13]

191—85.11(505,522D) Continuing education requirements for navigators.

85.11(1) Prior to each renewal term, individual navigators must complete a minimum of 36 continuing education credits for each continuing education term in courses approved by the commissioner on subjects relevant to navigators, including health insurance, tax credits, tax penalties,

Medicaid, the healthy and well kids in Iowa program, health care-related public assistance programs, or other ACA-related topics.

85.11(2) Courses provided by the federal government or approved by the federal government on ACA-related topics will be considered approved by the commissioner.

85.11(3) A navigator shall not carry over continuing education requirements from one term to the next term.

85.11(4) A navigator shall not receive continuing education credit for the same course taken twice in the term of license.

[ARC 0981C, IAB 8/21/13, effective 9/25/13]

191—85.12(505,522D) Administration of examinations.

85.12(1) The commissioner will enter into a contractual relationship with an outside testing service to provide the licensing examinations for individual navigators.

85.12(2) The outside testing service will administer all examinations for applicants.

85.12(3) The testing service will inform the applicants of procedures and requirements for taking the licensing examination.

85.12(4) The fee for examination shall be determined by the testing service.

85.12(5) A listing of subjects that could potentially be included on the navigator's examination may be provided on the division's Web site at <http://www.iid.state.ia.us/>.

85.12(6) Examination results are valid for 90 days after the date of the test. Failure to apply for licensure within 90 days after the examination is passed shall void the examination results.

[ARC 0981C, IAB 8/21/13, effective 9/25/13]

191—85.13(505,522D) Fees.

85.13(1) Fees may be paid by check or credit card.

85.13(2) The fee for issuance or renewal of a navigator license is \$20 for three years.

85.13(3) The fee for reinstatement of a navigator license is a total of the renewal fee plus \$100.

85.13(4) The division may charge a reasonable fee for the compilation and production of navigator licensing records.

[ARC 0981C, IAB 8/21/13, effective 9/25/13]

191—85.14(505,522D) Evidence of financial responsibility.

85.14(1) Prior to the issuance by the division of a license as a navigator and for the duration of the license, including any renewal thereof, a navigator shall secure and maintain evidence of financial responsibility in the form of a surety bond or other alternative financial responsibility instrument that protects individuals and entities against wrongful acts, misrepresentations, errors, omissions, or negligence of the navigator, or other violation of insurance law.

85.14(2) The minimum coverage for financial responsibility shall be \$50,000.

85.14(3) A navigator shall immediately inform the commissioner in writing of any pending termination of a written financial responsibility instrument. The navigator shall secure a new financial responsibility instrument and provide evidence of new financial responsibility to the commissioner prior to the date of termination for the existing financial responsibility instrument. If evidence of a new financial responsibility instrument is not provided to the commissioner prior to termination, the navigator's license shall be forfeited.

85.14(4) An individual navigator may meet the financial responsibility requirement if the individual navigator is covered by the financial responsibility instrument issued to a navigator entity with which the individual navigator is affiliated.

85.14(5) A navigator's financial responsibility instrument shall specifically authorize recovery by the commissioner on behalf of any person in Iowa that sustained damages as the result of wrongful acts, misrepresentations, errors, omissions, or negligence of the navigator, or other violation of insurance law in the individual's or entity's capacity as a navigator.

[ARC 0981C, IAB 8/21/13, effective 9/25/13]

191—85.15(505,522D) Practices.

85.15(1) Navigators shall comply with all federal and state statutes, regulations, and rules affecting insurance and navigators.

85.15(2) Navigators shall comply with any inquiries or requests submitted by the commissioner. Navigators shall respond to requests by the commissioner within the time designated in the request. A navigator that fails to provide the information in the time requested or fails to obtain an approved extension shall be subject to penalties as set forth in Iowa Code section 522D.8.

85.15(3) Navigators shall be subject to examination upon the discretion of the commissioner and at the cost of the navigator.

85.15(4) Navigators shall maintain detailed records of all assistance provided. Consumer assistance records shall be available to the commissioner upon request.

85.15(5) Navigators shall provide duplicate copies of all data and information submitted to the U.S. Department of Health and Human Services to the commissioner upon request.

85.15(6) Unless licensed as a producer, a navigator shall not:

- a. Sell, select, solicit, refer, or negotiate insurance coverage for individuals or entities;
- b. Advise an individual or entity to cancel, to nonrenew, or to select different insurance coverage;
- c. Recommend or endorse a particular health plan; and
- d. Receive compensation from an insurance company for enrollment or have a conflict of interest while serving as a navigator. A navigator that receives compensation from an insurance company for enrollment or enters into a conflicted relationship must forfeit the navigator's license. A navigator that fails to notify the commissioner of a conflicted relationship or receives compensation from an insurer for enrollment while licensed as a navigator shall be subject to penalties as set forth in Iowa Code section 522D.8.

[ARC 0981C, IAB 8/21/13, effective 9/25/13]

191—85.16(505,522D) Severability. If any provision of this chapter or its application to any person or circumstance is held invalid by a court of competent jurisdiction or by federal law, the invalidity does not affect other provisions or applications of the chapter that can be given effect without the invalid provision or application, and to this end the provisions of this chapter that are severable and the valid provisions or applications shall remain in full force and effect.

[ARC 0981C, IAB 8/21/13, effective 9/25/13]

These rules are intended to implement Iowa Code section 505.8(19) and chapter 522D.

[Filed ARC 0981C (Notice ARC 0816C, IAB 6/26/13), IAB 8/21/13, effective 9/25/13]

[Filed ARC 1710C (Notice ARC 1592C, IAB 8/20/14), IAB 10/29/14, effective 12/3/14]

CHAPTER 31
ECONOMIC DEVELOPMENT REGION INITIATIVES

261—31.1(15E) Purpose. Authority resources may be available to assist an economic development region that has established a focused economic development effort. This effort shall include a regional development plan relating to one or more of the following areas:

1. Regional marketing strategies.
 2. Development of the information solutions sector.
 3. Development of the advanced manufacturing sector.
 4. Development of the life sciences and biotechnology sector.
 5. Development of the insurance or financial services sector.
 6. Physical infrastructure including, but not limited to, horizontal infrastructure, water and sewer infrastructure, and telecommunications infrastructure.
 7. Entrepreneurship.
 8. Development of the alternative and renewable energy sector.
- [ARC 1626C, IAB 9/17/14, effective 10/22/14; see Delay note at end of chapter]

261—31.2(15E) Types of assistance. The following types of assistance are governed by the divisions of this chapter:

1. Establishment of economic development regions.
 2. Economic development revolving loan funds.
 3. Business accelerators.
 4. Small business development center assistance.
 5. Iowa business resource assistance.
- [ARC 1626C, IAB 9/17/14, effective 10/22/14; see Delay note at end of chapter]

261—31.3(15E) Financial assistance. Financial assistance under the economic development region initiative comes from the moneys allocated for such purposes by the authority pursuant to Iowa Code section 15.335B.

[ARC 1626C, IAB 9/17/14, effective 10/22/14; see Delay note at end of chapter]

261—31.4(15E) Definitions.

“Economic development region” shall consist of three or more contiguous counties or two or more contiguous counties and one or more public or private, nonprofit entities that have entered into an agreement to pursue mutual economic development goals with a regional focus.

“Economic development region assistance fund” means a fund created pursuant to Iowa Code section 15.335B.

“Economic development region revolving fund” means a fund established to benefit development efforts in an economic development region.

“Regional economic development revenue sharing pilot project” means a pilot project for one or more approved regions.

[ARC 1626C, IAB 9/17/14, effective 10/22/14; see Delay note at end of chapter]

DIVISION I
ECONOMIC DEVELOPMENT REGION INITIATIVE—FINANCIAL ASSISTANCE

261—31.5(15E) Uses of funds under the economic development region initiative. Financial assistance from the economic development region assistance fund may be used for the following:

31.5(1) Physical infrastructure. The installation of physical infrastructure needs including, but not limited to, horizontal infrastructure, water and sewer infrastructure, and telecommunications infrastructure, related to the development of fully served business and industrial sites by one or more of the region’s economic development partners or for the installation of infrastructure related to a new business location or expansion. Match is one dollar of local funds for every two dollars received

from the economic development region assistance fund. The economic development region must demonstrate all of the following:

- a. The ability to provide matching moneys on a basis of dollars received from the economic development region assistance fund.
- b. The commitment of the specific business partner including, but not limited to, a letter of intent defining a capital commitment or a percentage of equity.
- c. That all other funding alternatives have been exhausted.

31.5(2) *Regional economic development revenue sharing pilot project.* Establishment and administration of a regional economic development revenue sharing pilot project for one or more regions.

31.5(3) *Entrepreneurial initiative.* Establishment of an approved entrepreneurial initiative. Match is one dollar of local funds for every two dollars received from the economic development region assistance fund.

31.5(4) *Business closure due to consolidation.* An existing business threatened with closure due to a potential consolidation to an out-of-state location. The economic development region may apply for financial assistance from the economic development region assistance fund for the purchase, rehabilitation, or marketing of a building that has become available due to the closing of an existing business as a result of a consolidation to an out-of-state location. Match is one dollar of local funds for every three dollars received from the economic development region assistance fund.

31.5(5) *Business succession assistance program.* Match is one dollar of local funds for every two dollars received from the economic development region assistance fund.

31.5(6) *Unique or innovative regional projects.* Match is on a one-to-one basis.

[ARC 1626C, IAB 9/17/14, effective 10/22/14; see Delay note at end of chapter]

261—31.6(15E) Application process and approval process.

31.6(1) *Application process.* The authority will only accept competitive applications submitted during the filing window. For the purpose of this rule, the filing window shall start on July 1 and end on July 15 of any fiscal year in which the authority opens the application process. If July 15 falls on a weekend, the deadline shall be extended to the next business day. The authority has developed an application process and will post all relevant application information on iowagrants.gov.

31.6(2) *Approval process.* The director of the authority will establish a review committee consisting of the authority's industry partners. The committee may recommend full or partial funding or no funding of any or all applicants.

[ARC 1626C, IAB 9/17/14, effective 10/22/14; see Delay note at end of chapter]

261—31.7(15E) Reporting requirements. Award recipients in economic development regions shall provide a close-out report to the authority outlining how the funds were invested in Iowa's future. The authority shall develop the reporting format for all required close-out reports.

[ARC 1626C, IAB 9/17/14, effective 10/22/14; see Delay note at end of chapter]

DIVISION II ECONOMIC ENTERPRISE AREAS

261—31.8(15E) Description. An "economic enterprise area" means a designated "economic development region" that shall consist of at least one county containing no city with a population of more than 23,500 and shall meet at least three of the following criteria:

1. A per capita income of 80 percent or less than the national average.
2. A household median income of 80 percent or less than the national average.
3. Twenty-five percent or more of the population of the economic enterprise area with an income level of 150 percent or less of the United States poverty level as defined by the most recently revised poverty income guidelines published by the United States Department of Health and Human Services.
4. A population density in the economic enterprise area of less than ten people per square mile.

5. A loss of population as shown by the 2000 certified federal census when compared with the 1990 certified federal census.

6. An unemployment rate greater than the national rate of unemployment.

7. More than 20 percent of the population of the economic enterprise area consisting of people over the age of 65.

[ARC 1626C, IAB 9/17/14, effective 10/22/14; see Delay note at end of chapter]

261—31.9(15E) Funding.

31.9(1) Approved areas may apply for up to \$75,000 each fiscal year until June 30, 2015. The actual amount available each year will be established by the authority in the annual allocation of funds for economic development region initiatives described in 261—paragraph 2.4(7) “b.” No more than ten economic development regions may be approved by the authority as economic enterprise areas.

31.9(2) In order to receive financial assistance under this division, an economic enterprise area must demonstrate the ability to provide local matching moneys on a basis of a one dollar contribution of local moneys for every three dollars received from the economic development region assistance fund.

[ARC 1626C, IAB 9/17/14, effective 10/22/14; see Delay note at end of chapter]

261—31.10(15E) Eligible use of funds. Funds available for economic enterprise areas may be used as follows:

1. Economic development-related strategic planning and marketing for the region as a whole.
2. Economic development of fully served business sites.
3. The construction of speculative buildings on a fully served lot.
4. The rehabilitation of an existing building to marketable standards.

[ARC 1626C, IAB 9/17/14, effective 10/22/14; see Delay note at end of chapter]

261—31.11(15E) Application process and approval process.

31.11(1) *Application process.* The authority will only accept competitive applications submitted during the filing window. For the purpose of this rule, the filing window shall start on July 1 and end on July 15 of any fiscal year in which the authority opens the application process. If July 15 falls on a weekend, the deadline shall be extended to the next business day. The authority has developed an application process and will post all relevant application information on iowagrants.gov.

31.11(2) *Approval process.* The director of the authority will establish a review committee consisting of the authority’s industry partners. The committee may recommend full or partial funding or no funding of any or all applicants.

[ARC 1626C, IAB 9/17/14, effective 10/22/14; see Delay note at end of chapter]

261—31.12(15E) Reporting requirements. Award recipients shall provide a close-out report to the authority outlining how funds were invested in Iowa’s future.

[ARC 1626C, IAB 9/17/14, effective 10/22/14; see Delay note at end of chapter]

DIVISION III BUSINESS ACCELERATORS

261—31.13(15E) Description and purpose. The authority may establish and administer a business accelerator program to provide financial assistance for the establishment and operation of a business accelerator for technology-based, value-added agricultural, information solutions, or advanced manufacturing start-up businesses or for a satellite of an existing business accelerator. The program may be designed to foster the accelerated growth of new and existing businesses through the provision of technical assistance.

[ARC 1626C, IAB 9/17/14, effective 10/22/14; see Delay note at end of chapter]

261—31.14(15E) Definitions.

“*Business accelerator*” means an organization that fosters the accelerated growth of new and existing Iowa businesses.

[ARC 1626C, IAB 9/17/14, effective 10/22/14; see Delay note at end of chapter]

261—31.15(15E) Requirements and qualifications for business accelerator entities. Business accelerator applicants must meet all of the following criteria:

1. The business accelerator must be a not-for-profit organization affiliated with an area chamber of commerce, a community or county organization, or an economic development region.
2. The geographic area served by a business accelerator must include more than one county.
3. The business accelerator must possess the ability to provide service to a specific type of business as well as to meet the broad-based needs of other types of start-up entrepreneurs.
4. The business accelerator must possess the ability to market business accelerator services in the region and the state.
5. The business accelerator must possess the ability to communicate with and cooperate with other business accelerators and similar service providers in the state.
6. The business accelerator must possess the ability to engage various funding sources for start-up entrepreneurs.
7. The business accelerator must possess the ability to communicate with and cooperate with various entities for purposes of locating suitable facilities for clients of the business accelerator.
8. The business accelerator must possess the willingness to accept referrals from the economic development authority.
9. The business accelerator must refer 20 businesses per year to the Venture Network of Iowa.

[ARC 1626C, IAB 9/17/14, effective 10/22/14; see Delay note at end of chapter]

261—31.16(15E) Other considerations. In determining whether a business accelerator qualifies for financial assistance, the authority may consider any of the following:

1. The business experience of the business accelerator's professional staff.
2. The business plan review capacity of the business accelerator's professional staff.
3. The business accelerator's professional staff with demonstrated disciplines in all aspects of business experience.
4. The business accelerator's professional staff with access to external service providers including legal, accounting, marketing, and financial services.

[ARC 1626C, IAB 9/17/14, effective 10/22/14; see Delay note at end of chapter]

261—31.17(15E) Application procedures.

31.17(1) Application process and approval process.

a. Application process. The authority will only accept competitive applications submitted during the filing window. For the purpose of this rule, the filing window shall start on July 1 and end on July 15 of any fiscal year in which the authority opens the application process. If July 15 falls on a weekend, the deadline shall be extended to the next business day. The authority has developed an application process and will post all relevant application information on iowagrants.gov.

b. Approval process. The director of the authority will establish a review committee consisting of the authority's industry partners. The committee may recommend full or partial funding or no funding of any or all applicants.

31.17(2) All requests for financial assistance must demonstrate the ability to provide matching moneys on the basis of a two dollar contribution of recipient moneys for every one dollar received in financial assistance from the authority.

[ARC 1626C, IAB 9/17/14, effective 10/22/14; see Delay note at end of chapter]

261—31.18(15E) Reporting. Business accelerators receiving financial assistance under this rule must submit an annual report to the authority documenting progress.

[ARC 1626C, IAB 9/17/14, effective 10/22/14; see Delay note at end of chapter]

DIVISION IV
SMALL BUSINESS DEVELOPMENT CENTERS

261—31.19(81GA, HF868, HF809) Small business development center assistance. Rescinded ARC 1626C, IAB 9/17/14, effective 10/22/14; see Delay note at end of chapter.

DIVISION V
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261—31.20(81GA,HF868,HF809) Iowa business resource centers. Rescinded **ARC 1626C**, IAB 9/17/14, effective 10/22/14; see Delay note at end of chapter.

These rules are intended to implement 2013 Iowa Code sections 15E.231 to 15E.233; 2011 Iowa Acts, chapter 118, section 20; and 2014 Iowa Acts, Senate File 2359.

[Filed 10/21/05, Notice 8/3/05—published 11/9/05, effective 12/14/05]

[Filed ARC 1626C (Notice ARC 1540C, IAB 7/9/14), IAB 9/17/14, effective 10/22/14]¹

¹ October 22, 2014, effective date of ARC 1626C [31.1 to 31.20] delayed 70 days by the Administrative Rules Review Committee at its meeting held October 14, 2014.

IOWA FINANCE AUTHORITY[265]

[Prior to 7/26/85, Housing Finance Authority[495]]
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265—12.1(16) Qualified allocation plans.

12.1(1) *Four percent qualified allocation plan.* The qualified allocation plan entitled Iowa Finance Authority Low-Income Housing Tax Credit Program 4% Qualified Allocation Plan (“4% QAP”) shall be the qualified allocation plan for the allocation of 4 percent low-income housing tax credits consistent with IRC Section 42 and the applicable Treasury regulations and Iowa Code section 16.52. The 4% QAP is incorporated by reference pursuant to Iowa Code section 17A.6 and 265—subrules 17.4(2) and 17.12(2). The 4% QAP does not include any amendments or editions created subsequent to October 8, 2014.

12.1(2) *Nine percent qualified allocation plan.* The qualified allocation plan entitled Iowa Finance Authority Low-Income Housing Tax Credit Program 2015 Qualified Allocation Plan (“9% QAP”) shall be the qualified allocation plan for the allocation of 9 percent low-income housing tax credits consistent with IRC Section 42 and the applicable Treasury regulations and Iowa Code section 16.52. The 9% QAP is incorporated by reference pursuant to Iowa Code section 17A.6 and 265—subrules 17.4(2) and 17.12(2). The 9% QAP does not include any amendments or editions created subsequent to October 8, 2014.

[ARC 8266B, IAB 11/4/09, effective 12/9/09; ARC 8947B, IAB 7/28/10, effective 7/6/10; ARC 9279B, IAB 12/15/10, effective 1/19/11; ARC 9950B, IAB 12/28/11, effective 2/1/12; ARC 0427C, IAB 10/31/12, effective 12/5/12; ARC 1139C, IAB 10/30/13, effective 12/4/13; ARC 1700C, IAB 10/29/14, effective 12/3/14]

265—12.2(16) Location of copies of the plans.

12.2(1) *4% QAP.* The 4% QAP can be reviewed and copied in its entirety on the authority’s Web site at <http://www.iowafinanceauthority.gov>. Copies of the 4% QAP, application, and all related attachments and exhibits shall be deposited with the administrative rules coordinator and at the state law library and shall be available on the authority’s Web site. The 4% QAP incorporates by reference IRC Section 42 and the regulations in effect as of October 8, 2014. Additionally, the 4% QAP incorporates by reference Iowa Code section 16.52. These documents are available from the state law library, and information about these statutes, regulations and rules is on the authority’s Web site.

12.2(2) *9% QAP.* The 9% QAP can be reviewed and copied in its entirety on the authority’s Web site at <http://www.iowafinanceauthority.gov>. Copies of the 9% QAP, application, and all related attachments and exhibits shall be deposited with the administrative rules coordinator and at the state law library and shall be available on the authority’s Web site. The 9% QAP incorporates by reference IRC Section 42 and the regulations in effect as of October 8, 2014. Additionally, the 9% QAP incorporates by reference Iowa Code section 16.52. These documents are available from the state law library, and information about these statutes, regulations and rules is on the authority’s Web site.

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265—12.3(16) Compliance manual. Rescinded ARC 1700C, IAB 10/29/14, effective 12/3/14.

265—12.4(16) Location of copies of the manual. Rescinded ARC 1700C, IAB 10/29/14, effective 12/3/14.

These rules are intended to implement Iowa Code section 16.52.

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CHAPTER 5
CONTESTED CASES
[Prior to 10/15/03, see 283—Ch 4]

283—5.1(17A) Scope and applicability. This chapter applies to contested case proceedings conducted by the college student aid commission.

283—5.2(17A) Definitions. Except where otherwise specifically defined by law:

“*Contested case*” means a proceeding defined by Iowa Code section 17A.2(5) and includes any matter defined as a no factual dispute contested case under Iowa Code section 17A.10A.

“*Issuance*” means the date of mailing of a decision or order or date of delivery if service is by other means unless another date is specified in the order.

“*Party*” means each person or agency named or admitted as a party or properly seeking and entitled as of right to be admitted as a party.

“*Presiding officer*” means the executive director.

“*Proposed decision*” means the presiding officer’s recommended findings of fact, conclusions of law, decision, and order in a contested case in which the college student aid commission did not preside.

283—5.3(17A) Time requirements.

5.3(1) Time shall be computed as provided in Iowa Code section 4.1(34).

5.3(2) For good cause, the presiding officer may extend or shorten the time to take any action, except as precluded by statute. Except for good cause stated in the record, before extending or shortening the time to take any action, the presiding officer shall afford all parties an opportunity to be heard or to file written arguments.

283—5.4(17A) Requests for contested case proceeding. Any person claiming an entitlement to a contested case proceeding shall file a written request for such a proceeding within the time specified by the particular rules or statutes governing the subject matter or, in the absence of such law, the time specified in the commission action in question.

The request for a contested case proceeding should state the name and address of the requester, identify the specific commission action which is disputed, and, where the requester is represented by a lawyer, identify the provisions of law or precedent requiring or authorizing the holding of a contested case proceeding in the particular circumstances involved, and include a short and plain statement of the issues of material fact in dispute.

283—5.5(17A) Notice of hearing.

5.5(1) Delivery. Delivery of the notice of hearing constitutes the commencement of the contested case proceeding. Delivery may be executed by:

- a. Personal service as provided in the Iowa Rules of Civil Procedure; or
- b. Certified mail, return receipt requested; or
- c. First-class mail; or
- d. Publication, as provided in the Iowa Rules of Civil Procedure.

5.5(2) Contents. The notice of hearing shall contain the following information:

- a. A statement of the time, place, and nature of the hearing;
- b. A statement of the legal authority and jurisdiction under which the hearing is to be held;
- c. A reference to the particular sections of the statutes and rules involved;
- d. A short and plain statement of the matters asserted. If the commission or other party is unable to state the matters in detail at the time the notice is served, the initial notice may be limited to a statement of the issues involved. Thereafter, upon application, a more definite and detailed statement shall be furnished;
- e. Identification of all parties including the name, address and telephone number of the person who will act as advocate for the commission or the state and of parties’ counsel where known;
- f. Reference to the procedural rules governing conduct of the contested case proceeding;

- g.* Reference to the procedural rules governing informal settlement;
- h.* Identification of the presiding officer, if known. If not known, a description of who will serve as presiding officer (e.g., agency head, members of multimembered agency head, administrative law judge from the department of inspections and appeals); and
- i.* Notification of the time period in which a party may request, pursuant to Iowa Code section 17A.11(1) and rule 283—5.6(17A), that the presiding officer be an administrative law judge.

283—5.6(17A) Presiding officer.

5.6(1) Any party who wishes to request that the presiding officer assigned to render a proposed decision be an administrative law judge employed by the department of inspections and appeals must file a written request within 20 days or such other time period the commission designates after service of a notice of hearing which identifies or describes the presiding officer as the executive director or members of the commission.

5.6(2) The commission or its designee may deny the request only upon a finding that one or more of the following apply:

- a.* Neither the commission nor any officer of the commission under whose authority the contested case is to take place is a named party to the proceeding or a real party in interest to that proceeding.
- b.* There is a compelling need to expedite issuance of a final decision in order to protect the public health, safety, or welfare.
- c.* A qualified administrative law judge is unavailable to hear the case within a reasonable time.
- d.* The case involves significant policy issues of first impression that are inextricably intertwined with the factual issues presented.
- e.* The demeanor of the witnesses is likely to be dispositive in resolving the disputed factual issues.
- f.* Funds are unavailable to pay the costs of an administrative law judge and an interagency appeal.
- g.* The request was not timely filed.
- h.* The request is not consistent with a specified statute.

5.6(3) The commission or its designee shall issue a written ruling specifying the grounds for its decision within 20 days or such other time period the commission designates after a request for an administrative law judge is filed. The parties shall be notified at least 10 days prior to hearing if a qualified administrative law judge will not be available.

5.6(4) Except as provided otherwise by another provision of law, all rulings by an administrative law judge acting as presiding officer are subject to appeal to the commission. A party must seek any available intra-agency appeal in order to exhaust adequate administrative remedies.

5.6(5) Unless otherwise provided by law, agency heads and members of multimembered agency heads, when reviewing a proposed decision upon intra-agency appeal, shall have the powers of and shall comply with the provisions of this chapter which apply to presiding officers.

283—5.7(17A) Waiver of procedures. Unless otherwise precluded by law, the parties in a contested case proceeding may waive any provision of this chapter. However, the commission, in its discretion, may refuse to give effect to such a waiver when it deems the waiver to be inconsistent with the public interest.

283—5.8(17A) Telephone proceedings. The presiding officer may resolve preliminary procedural motions by telephone conference in which all parties have an opportunity to participate. Other telephone proceedings may be held with the consent of all parties. The presiding officer will determine the location of the parties and witnesses for telephone hearings. The convenience of the witnesses or parties, as well as the nature of the case, will be considered when location is chosen.

283—5.9(17A) Disqualification.

5.9(1) A presiding officer or other person shall withdraw from participation in the making of any proposed or final decision in a contested case if that person:

- a.* Has a personal bias or prejudice concerning a party or a representative of a party;

b. Has personally investigated, prosecuted or advocated in connection with that case, the specific controversy underlying that case, another pending factually related contested case, or a pending factually related controversy that may culminate in a contested case involving the same parties;

c. Is subject to the authority, direction or discretion of any person who has personally investigated, prosecuted or advocated in connection with that contested case, the specific controversy underlying that contested case, or a pending factually related contested case or controversy involving the same parties;

d. Has acted as counsel to any person who is a private party to that proceeding within the past two years;

e. Has a personal financial interest in the outcome of the case or any other significant personal interest that could be substantially affected by the outcome of the case;

f. Has a spouse or relative within the third degree of relationship that: (1) is a party to the case, or an officer, director or trustee of a party; (2) is a lawyer in the case; (3) is known to have an interest that could be substantially affected by the outcome of the case; or (4) is likely to be a material witness in the case; or

g. Has any other legally sufficient cause to withdraw from participation in the decision making in that case.

5.9(2) The term “personally investigated” means taking affirmative steps to interview witnesses directly or to obtain documents or other information directly. The term “personally investigated” does not include general direction and supervision of assigned investigators, unsolicited receipt of information which is relayed to assigned investigators, review of another person’s investigative work product in the course of determining whether there is probable cause to initiate a proceeding, or exposure to factual information while performing other commission functions, including fact gathering for purposes other than investigation of the matter which culminates in a contested case. Factual information relevant to the merits of a contested case received by a person who later serves as presiding officer in that case shall be disclosed if required by Iowa Code section 17A.17(3) and subrules 5.9(3) and 5.23(9).

5.9(3) In a situation where a presiding officer or other person knows of information which might reasonably be deemed to be a basis for disqualification and decides voluntary withdrawal is unnecessary, that person shall submit the relevant information for the record by affidavit and shall provide for the record a statement of the reasons for the determination that withdrawal is unnecessary.

5.9(4) If a party asserts disqualification on any appropriate ground, including those listed in subrule 5.9(1), the party shall file a motion supported by an affidavit pursuant to Iowa Code section 17A.17(7). The motion must be filed as soon as practicable after the reason alleged in the motion becomes known to the party.

If, during the course of the hearing, a party first becomes aware of evidence of bias or other grounds for disqualification, the party may move for disqualification but must establish the grounds by the introduction of evidence into the record.

If the presiding officer determines that disqualification is appropriate, the presiding officer or other person shall withdraw. If the presiding officer determines that withdrawal is not required, the presiding officer shall enter an order to that effect. A party asserting disqualification may seek an interlocutory appeal under rule 283—5.25(17A) and seek a stay under rule 283—5.29(17A).

283—5.10(17A) Consolidation—severance.

5.10(1) Consolidation. The presiding officer may consolidate any or all matters at issue in two or more contested case proceedings where: (a) the matters at issue involve common parties or common questions of fact or law; (b) consolidation would expedite and simplify consideration of the issues involved; and (c) consolidation would not adversely affect the rights of any of the parties to those proceedings.

5.10(2) Severance. The presiding officer may, for good cause shown, order any contested case proceedings or portions thereof severed.

283—5.11(17A) Pleadings.

5.11(1) Pleadings may be required by rule, by the notice of hearing, or by order of the presiding officer.

5.11(2) Petition.

a. Any petition required in a contested case proceeding shall be filed within 20 days of delivery of the notice of hearing or subsequent order of the presiding officer, unless otherwise ordered.

b. A petition shall state in separately numbered paragraphs the following:

- (1) The persons or entities on whose behalf the petition is filed;
- (2) The particular provisions of statutes and rules involved;
- (3) The relief demanded and the facts and law relied upon for such relief; and
- (4) The name, address and telephone number of the petitioner and the petitioner's attorney, if any.

5.11(3) Answer. An answer shall be filed within 20 days of service of the petition unless otherwise ordered. A party may move to dismiss or apply for a more definite and detailed statement when appropriate.

An answer shall show on whose behalf it is filed and specifically admit, deny, or otherwise answer all material allegations of the pleading to which it responds. It shall state any facts deemed to show an affirmative defense and contain as many additional defenses as the pleader may claim.

An answer shall state the name, address and telephone number of the person filing the answer, the person or entity on whose behalf it is filed, and the attorney representing that person, if any.

Any allegation in the petition not denied in the answer is considered admitted. The presiding officer may refuse to consider any defense not raised in the answer which could have been raised on the basis of facts known when the answer was filed if any party would be prejudiced.

5.11(4) Amendment. Any notice of hearing, petition, or other charging document may be amended before a responsive pleading has been filed. Amendments to pleadings after a responsive pleading has been filed and to an answer may be allowed with the consent of the other parties or in the discretion of the presiding officer who may impose terms or grant a continuance.

283—5.12(17A) Service and filing of pleadings and other papers.

5.12(1) *When service required.* Except where otherwise provided by law, every pleading, motion, document, or other paper filed in a contested case proceeding and every paper relating to discovery in such a proceeding shall be served upon each of the parties of record to the proceeding, including the person designated as advocate or prosecutor for the state or the commission, simultaneously with their filing. Except for the original notice of hearing and an application for rehearing as provided in Iowa Code section 17A.16(2), the party filing a document is responsible for service on all parties.

5.12(2) *Service—how made.* Service upon a party represented by an attorney shall be made upon the attorney unless otherwise ordered. Service is made by delivery or by mailing a copy to the person's last-known address. Service by mail is complete upon mailing, except where otherwise specifically provided by statute, rule, or order.

5.12(3) *Filing—when required.* After the notice of hearing, all pleadings, motions, documents or other papers in a contested case proceeding shall be filed with the college student aid commission.

5.12(4) *Filing—when made.* Except where otherwise provided by law, a document is deemed filed at the time it is delivered to the college student aid commission, delivered to an established courier service for immediate delivery to that office, or mailed by first-class mail or state interoffice mail to that office, so long as there is proof of mailing.

5.12(5) *Proof of mailing.* Proof of mailing includes either: a legible United States Postal Service postmark on the envelope, a certificate of service, a notarized affidavit, or a certification in substantially the following form:

I certify under penalty of perjury and pursuant to the laws of Iowa that, on (date of mailing), I mailed copies of (describe document) addressed to the College Student Aid Commission, 430 East Grand Avenue, Third Floor, Des Moines, Iowa 50309-1920, and to the names and addresses of the parties listed below by depositing the same in (a United States post office mailbox with correct postage properly affixed or state interoffice mail).

(Date) (Signature)

[ARC 1684C, IAB 10/29/14, effective 12/3/14]

283—5.13(17A) Discovery.

5.13(1) Discovery procedures applicable in civil actions are applicable in contested cases. Unless lengthened or shortened by these rules or by order of the presiding officer, time periods for compliance with discovery shall be as provided in the Iowa Rules of Civil Procedure.

5.13(2) Any motion relating to discovery shall allege that the moving party has previously made a good-faith attempt to resolve the discovery issues involved with the opposing party. Motions in regard to discovery shall be ruled upon by the presiding officer. Opposing parties shall be afforded the opportunity to respond within ten days of the filing of the motion unless the time is shortened as provided in subrule 5.13(1). The presiding officer may rule on the basis of the written motion and any response, or may order argument on the motion.

5.13(3) Evidence obtained in discovery may be used in the contested case proceeding if that evidence would otherwise be admissible in that proceeding.

283—5.14(17A) Subpoenas.

5.14(1) Issuance.

a. An agency subpoena shall be issued to a party on request. Such a request must be in writing. In the absence of good cause for permitting later action, a request for a subpoena must be received at least three days before the scheduled hearing. The request shall include the name, address, and telephone number of the requesting party.

b. Except to the extent otherwise provided by law, parties are responsible for service of their own subpoenas and payment of witness fees and mileage expenses.

5.14(2) Motion to quash or modify. The presiding officer may quash or modify a subpoena for any lawful reason upon motion in accordance with the Iowa Rules of Civil Procedure. A motion to quash or modify a subpoena shall be set for argument promptly.

283—5.15(17A) Motions.

5.15(1) No technical form for motions is required. However, prehearing motions must be in writing, state the grounds for relief, and state the relief sought.

5.15(2) Any party may file a written response to a motion within ten days after the motion is served, unless the time period is extended or shortened by rules of the commission or the presiding officer. The presiding officer may consider a failure to respond within the required time period in ruling on a motion.

5.15(3) The presiding officer may schedule oral argument on any motion.

5.15(4) Motions pertaining to the hearing, except motions for summary judgment, must be filed and served at least ten days prior to the date of hearing unless there is good cause for permitting later action or the time for such action is lengthened or shortened by rule of the commission or an order of the presiding officer.

5.15(5) Motions for summary judgment. Motions for summary judgment shall comply with the requirements of Iowa Rule of Civil Procedure 1.981 and shall be subject to disposition according to the requirements of that rule to the extent such requirements are not inconsistent with the provisions of this rule or any other provision of law governing the procedure in contested cases.

Motions for summary judgment must be filed and served at least 45 days prior to the scheduled hearing date, or other time period determined by the presiding officer. Any party resisting the motion shall file and serve a resistance within 15 days, unless otherwise ordered by the presiding officer, from the date a copy of the motion was served. The time fixed for hearing or nonoral submission shall be not

less than 20 days after the filing of the motion, unless a shorter time is ordered by the presiding officer. A summary judgment order rendered on all issues in a contested case is subject to rehearing pursuant to 283—5.28(17A) and appeal pursuant to 283—5.27(17A).

283—5.16(17A) Prehearing conference.

5.16(1) Any party may request a prehearing conference. A written request for prehearing conference or an order for prehearing conference on the presiding officer's own motion shall be filed not less than seven days prior to the hearing date. A prehearing conference shall be scheduled not less than three business days prior to the hearing date.

Written notice of the prehearing conference shall be given by the executive director to all parties. For good cause the presiding officer may permit variances from this rule.

5.16(2) Each party shall bring to the prehearing conference:

a. A final list of the witnesses who the party anticipates will testify at hearing. Witnesses not listed may be excluded from testifying unless there was good cause for the failure to include their names; and

b. A final list of exhibits which the party anticipates will be introduced at hearing. Exhibits other than rebuttal exhibits that are not listed may be excluded from admission into evidence unless there was good cause for the failure to include them.

c. Witness or exhibit lists may be amended subsequent to the prehearing conference within the time limits established by the presiding officer at the prehearing conference. Any such amendments must be served on all parties.

5.16(3) In addition to the requirements of subrule 5.16(2), the parties at a prehearing conference may:

a. Enter into stipulations of law or fact;

b. Enter into stipulations on the admissibility of exhibits;

c. Identify matters which the parties intend to request be officially noticed;

d. Enter into stipulations for waiver of any provision of law; and

e. Consider any additional matters which will expedite the hearing.

5.16(4) Prehearing conferences shall be conducted by telephone unless otherwise ordered. Parties shall exchange and receive witness and exhibit lists in advance of a telephone prehearing conference.

283—5.17(17A) Continuances. Unless otherwise provided, applications for continuances shall be made to the presiding officer.

5.17(1) A written application for a continuance shall:

a. Be made at the earliest possible time and no less than seven days before the hearing except in case of unanticipated emergencies;

b. State the specific reasons for the request; and

c. Be signed by the requesting party or the party's representative.

An oral application for a continuance may be made if the presiding officer waives the requirement for a written motion. However, a party making such an oral application for a continuance must confirm that request by written application within five days after the oral request unless that requirement is waived by the presiding officer. No application for continuance shall be made or granted without notice to all parties except in an emergency where notice is not feasible. The commission may waive notice of such requests for a particular case or an entire class of cases.

5.17(2) In determining whether to grant a continuance, the presiding officer may consider:

a. Prior continuances;

b. The interests of all parties;

c. The likelihood of informal settlement;

d. The existence of an emergency;

e. Any objection;

f. Any applicable time requirements;

g. The existence of a conflict in the schedules of counsel, parties, or witnesses;

h. The timeliness of the request; and

i. Other relevant factors.

The presiding officer may require documentation of any grounds for continuance.

283—5.18(17A) Withdrawals. A party requesting a contested case proceeding may withdraw that request prior to the hearing only in accordance with commission rules. Unless otherwise provided, a withdrawal shall be with prejudice.

283—5.19(17A) Intervention.

5.19(1) Motion. A motion for leave to intervene in a contested case proceeding shall state the grounds for the proposed intervention, the position and interest of the proposed intervenor, and the possible impact of intervention on the proceeding. A proposed answer or petition in intervention shall be attached to the motion. Any party may file a response within 14 days of service of the motion to intervene unless the time period is extended or shortened by the presiding officer.

5.19(2) When filed. Motion for leave to intervene shall be filed as early in the proceeding as possible to avoid adverse impact on existing parties or the conduct of the proceeding. Unless otherwise ordered, a motion for leave to intervene shall be filed before the prehearing conference, if any, or at least 20 days before the date scheduled for hearing. Any later motion must contain a statement of good cause for the failure to file in a timely manner. Unless inequitable or unjust, an intervenor shall be bound by any agreement, arrangement, or other matter previously raised in the case. Requests by untimely intervenors for continuances which would delay the proceeding will ordinarily be denied.

5.19(3) Grounds for intervention. The movant shall demonstrate that: (a) intervention would not unduly prolong the proceedings or otherwise prejudice the rights of existing parties; (b) the movant is likely to be aggrieved or adversely affected by a final order in the proceeding; and (c) the interests of the movant are not adequately represented by existing parties.

5.19(4) Effect of intervention. If appropriate, the presiding officer may order consolidation of the petitions and briefs of different parties whose interests are aligned with each other and limit the number of representatives allowed to participate actively in the proceedings. A person granted leave to intervene is a party to the proceeding. The order granting intervention may restrict the issues that may be raised by the intervenor or otherwise condition the intervenor's participation in the proceeding.

283—5.20(17A) Hearing procedures.

5.20(1) The presiding officer presides at the hearing, and may rule on motions, require briefs, issue a proposed decision, and issue such orders and rulings as will ensure the orderly conduct of the proceedings.

5.20(2) All objections shall be timely made and stated on the record.

5.20(3) Parties have the right to participate or to be represented in all hearings or prehearing conferences related to their case. Partnerships, corporations, or associations may be represented by any member, officer, director, or duly authorized agent. Any party may be represented by an attorney or another person authorized by law.

5.20(4) Subject to terms and conditions prescribed by the presiding officer, parties have the right to introduce evidence on issues of material fact, cross-examine witnesses present at the hearing as necessary for a full and true disclosure of the facts, present evidence in rebuttal, and submit briefs and engage in oral argument.

5.20(5) The presiding officer shall maintain the decorum of the hearing and may refuse to admit or may expel anyone whose conduct is disorderly.

5.20(6) Witnesses may be sequestered during the hearing.

5.20(7) The presiding officer shall conduct the hearing in the following manner:

a. The presiding officer shall give an opening statement briefly describing the nature of the proceedings;

b. The parties shall be given an opportunity to present opening statements;

c. Parties shall present their cases in the sequence determined by the presiding officer;

d. Each witness shall be sworn or affirmed by the presiding officer or the court reporter, and be subject to examination and cross-examination. The presiding officer may limit questioning in a manner consistent with law;

e. When all parties and witnesses have been heard, parties may be given the opportunity to present final arguments.

283—5.21(17A) Evidence.

5.21(1) The presiding officer shall rule on admissibility of evidence and may, where appropriate, take official notice of facts in accordance with all applicable requirements of law.

5.21(2) Stipulation of facts is encouraged. The presiding officer may make a decision based on stipulated facts.

5.21(3) Evidence in the proceeding shall be confined to the issues as to which the parties received notice prior to the hearing unless the parties waive their right to such notice or the presiding officer determines that good cause justifies expansion of the issues. If the presiding officer decides to admit evidence on issues outside the scope of the notice over the objection of a party who did not have actual notice of those issues, that party, upon timely request, shall receive a continuance sufficient to amend pleadings and to prepare on the additional issue.

5.21(4) The party seeking admission of an exhibit must provide opposing parties with an opportunity to examine the exhibit prior to the ruling on its admissibility. Copies of documents should normally be provided to opposing parties.

All exhibits admitted into evidence shall be appropriately marked and be made part of the record.

5.21(5) Any party may object to specific evidence or may request limits on the scope of any examination or cross-examination. Such an objection shall be accompanied by a brief statement of the grounds upon which it is based. The objection, the ruling on the objection, and the reasons for the ruling shall be noted in the record. The presiding officer may rule on the objection at the time it is made or may reserve a ruling until the written decision.

5.21(6) Whenever evidence is ruled inadmissible, the party offering that evidence may submit an offer of proof on the record. The party making the offer of proof for excluded oral testimony shall briefly summarize the testimony or, with permission of the presiding officer, present the testimony. If the excluded evidence consists of a document or exhibit, it shall be marked as part of an offer of proof and inserted in the record.

283—5.22(17A) Default.

5.22(1) If a party fails to appear or participate in a contested case proceeding after proper service of notice, the presiding officer may, if no adjournment is granted, enter a default decision or proceed with the hearing and render a decision in the absence of the party.

5.22(2) Where appropriate and not contrary to law, any party may move for default against a party who has requested the contested case proceeding and has failed to file a required pleading or has failed to appear after proper service.

5.22(3) Default decisions or decisions rendered on the merits after a party has failed to appear or participate in a contested case proceeding become final commission action unless, within 15 days or other period of time specified by statute or rule after the date of notification or mailing of the decision, a motion to vacate is filed and served on all parties or an appeal of a decision on the merits is timely initiated within the time provided by rule 283—5.27(17A). A motion to vacate must state all facts relied upon by the moving party which establish that good cause existed for that party's failure to appear or participate at the contested case proceeding. Each fact so stated must be substantiated by at least one sworn affidavit of a person with personal knowledge of each such fact, which affidavit(s) must be attached to the motion.

5.22(4) The time for further appeal of a decision for which a timely motion to vacate has been filed is stayed pending a decision on the motion to vacate.

5.22(5) Properly substantiated and timely filed motions to vacate shall be granted only for good cause shown. The burden of proof as to good cause is on the moving party. Adverse parties shall have ten days or other time specified by the commission to respond to a motion to vacate. Adverse parties

shall be allowed to conduct discovery as to the issue of good cause and to present evidence on the issue prior to a decision on the motion, if a request to do so is included in that party's response.

5.22(6) "Good cause" for purposes of this rule shall have the same meaning as "good cause" for setting aside a default judgment under Iowa Rule of Civil Procedure 1.977.

5.22(7) A decision denying a motion to vacate is subject to further appeal within the time limit allowed for further appeal of a decision on the merits in the contested case proceeding. A decision granting a motion to vacate is subject to interlocutory appeal by the adverse party pursuant to rule 283—5.25(17A).

5.22(8) If a motion to vacate is granted and no timely interlocutory appeal has been taken, the presiding officer shall issue another notice of hearing and the contested case shall proceed accordingly.

5.22(9) A default decision may award any relief consistent with the request for relief made in the petition and embraced in its issues but, unless the defaulting party has appeared, it cannot exceed the relief demanded.

5.22(10) A default decision may provide either that the default decision is to be stayed pending a timely motion to vacate or that the default decision is to take effect immediately, subject to a request for stay under rule 283—5.29(17A).

283—5.23(17A) Ex parte communication.

5.23(1) Prohibited communications. Unless required for the disposition of ex parte matters specifically authorized by statute, following issuance of the notice of hearing, there shall be no communication, directly or indirectly, between the presiding officer and any party or representative of any party or any other person with a direct or indirect interest in such case in connection with any issue of fact or law in the case except upon notice and opportunity for all parties to participate. This does not prohibit persons jointly assigned such tasks from communicating with each other. Nothing in this provision is intended to preclude the presiding officer from communicating with members of the commission or seeking the advice or help of persons other than those with a personal interest in, or those engaged in personally investigating as defined in subrule 5.9(2), prosecuting, or advocating in, either the case under consideration or a pending factually related case involving the same parties as long as those persons do not directly or indirectly communicate to the presiding officer any ex parte communications they have received of a type that the presiding officer would be prohibited from receiving or that furnish, augment, diminish, or modify the evidence in the record.

5.23(2) Prohibitions on ex parte communications commence with the issuance of the notice of hearing in a contested case and continue for as long as the case is pending.

5.23(3) Written, oral or other forms of communication are "ex parte" if made without notice and opportunity for all parties to participate.

5.23(4) To avoid prohibited ex parte communications, notice must be given in a manner reasonably calculated to give all parties a fair opportunity to participate. Notice of written communications shall be provided in compliance with rule 283—5.12(17A) and may be supplemented by telephone, facsimile, electronic mail or other means of notification. Where permitted, oral communications may be initiated through conference telephone call including all parties or their representatives.

5.23(5) Persons who jointly act as presiding officer in a pending contested case may communicate with each other without notice or opportunity for parties to participate.

5.23(6) The executive director or other persons may be present in deliberations or otherwise advise the presiding officer without notice or opportunity for parties to participate as long as they are not disqualified from participating in the making of a proposed or final decision under any provision of law and they comply with subrule 5.23(1).

5.23(7) Communications with the presiding officer involving uncontested scheduling or procedural matters do not require notice or opportunity for parties to participate. Parties should notify other parties prior to initiating such contact with the presiding officer when feasible, and shall notify other parties when seeking to continue hearings or other deadlines pursuant to rule 283—5.17(17A).

5.23(8) Disclosure of prohibited communications. A presiding officer who receives a prohibited ex parte communication during the pendency of a contested case must initially determine if the effect of the

communication is so prejudicial that the presiding officer should be disqualified. If the presiding officer determines that disqualification is warranted, a copy of any prohibited written communication, all written responses to the communication, a written summary stating the substance of any prohibited oral or other communication not available in written form for disclosure, all responses made, and the identity of each person from whom the presiding officer received a prohibited ex parte communication shall be submitted for inclusion in the record under seal by protective order or disclosed. If the presiding officer determines that disqualification is not warranted, such documents shall be submitted for inclusion in the record and served on all parties. Any party desiring to rebut the prohibited communication must be allowed the opportunity to do so upon written request filed within ten days after notice of the communication.

5.23(9) Promptly after being assigned to serve as presiding officer at any stage in a contested case proceeding, a presiding officer shall disclose to all parties material factual information received through ex parte communication prior to such assignment unless the factual information has already been or shortly will be disclosed pursuant to Iowa Code section 17A.13(2) or through discovery. Factual information contained in an investigative report or similar document need not be separately disclosed by the presiding officer as long as such documents have been or will shortly be provided to the parties.

5.23(10) The presiding officer may render a proposed or final decision imposing appropriate sanctions for violations of this rule including default, a decision against the offending party, censure, or suspension or revocation of the privilege to practice before the commission. Violation of ex parte communication prohibitions by commission personnel shall be reported to the executive director for possible sanctions including censure, suspension, dismissal, or other disciplinary action.

283—5.24(17A) Recording costs. Upon request, the college student aid commission shall provide a copy of the whole or any portion of the record at cost. The cost of preparing a copy of the record or of transcribing the hearing record shall be paid by the requesting party.

Parties who request that a hearing be recorded by certified shorthand reporters rather than by electronic means shall bear the cost of that recordation, unless otherwise provided by law.

283—5.25(17A) Interlocutory appeals. Upon written request of a party or on its own motion, the commission may review an interlocutory order of the executive director. In determining whether to do so, the commission shall weigh the extent to which its granting the interlocutory appeal would expedite final resolution of the case and the extent to which review of that interlocutory order by the commission at the time it reviews the proposed decision of the presiding officer would provide an adequate remedy. Any request for interlocutory review must be filed within 14 days of issuance of the challenged order, but no later than the time for compliance with the order or the date of hearing, whichever is first.

283—5.26(17A) Final decision.

5.26(1) When the commission presides over the reception of evidence at the hearing, its decision is a final decision.

5.26(2) When the commission does not preside at the reception of evidence, the presiding officer shall make a proposed decision. The proposed decision becomes the final decision of the commission without further proceedings unless there is an appeal to, or review on motion of, the commission within the time provided in rule 283—5.27(17A).

283—5.27(17A) Appeals and review.

5.27(1) Appeal by party. Any adversely affected party may appeal a proposed decision to the commission within 30 days after issuance of the proposed decision.

5.27(2) Review. The commission may initiate review of a proposed decision on its own motion at any time within 30 days following the issuance of such a decision.

5.27(3) Notice of appeal. An appeal of a proposed decision is initiated by filing a timely notice of appeal with the college student aid commission. The notice of appeal must be signed by the appealing party or a representative of that party and contain a certificate of service. The notice shall specify:

- a. The parties initiating the appeal;

- b. The proposed decision or order appealed from;
- c. The specific findings or conclusions to which exception is taken and any other exceptions to the decision or order;
- d. The relief sought;
- e. The grounds for relief.

5.27(4) *Requests to present additional evidence.* A party may request the taking of additional evidence only by establishing that the evidence is material, that good cause existed for the failure to present the evidence at the hearing, and that the party has not waived the right to present the evidence. A written request to present additional evidence must be filed with the notice of appeal or, by a nonappealing party, within 14 days of service of the notice of appeal. The commission may remand a case to the presiding officer for further hearing or may itself preside at the taking of additional evidence.

5.27(5) *Scheduling.* The college student aid commission shall issue a schedule for consideration of the appeal.

5.27(6) *Briefs and arguments.* Unless otherwise ordered, within 20 days of the notice of appeal or order for review, each appealing party may file exceptions and briefs. Within 20 days thereafter, any party may file a responsive brief. Briefs shall cite any applicable legal authority and specify relevant portions of the record in that proceeding. Written requests to present oral argument shall be filed with the briefs. The commission may resolve the appeal on the briefs or provide an opportunity for oral argument. The commission may shorten or extend the briefing period as appropriate.

283—5.28(17A) Applications for rehearing.

5.28(1) *By whom filed.* Any party to a contested case proceeding may file an application for rehearing from a final order.

5.28(2) *Content of application.* The application for rehearing shall state on whose behalf it is filed, the specific grounds for rehearing, and the relief sought. In addition, the application shall state whether the applicant desires reconsideration of all or part of the commission decision on the existing record and whether, on the basis of the grounds enumerated in subrule 5.27(4), the applicant requests an opportunity to submit additional evidence.

5.28(3) *Time of filing.* The application shall be filed with the college student aid commission within 20 days after issuance of the final decision.

5.28(4) *Notice to other parties.* A copy of the application shall be timely mailed by the applicant to all parties of record not joining therein. If the application does not contain a certificate of service, the commission shall serve copies on all parties.

5.28(5) *Disposition.* Any application for a rehearing shall be deemed denied unless the commission grants the application within 20 days after its filing.

283—5.29(17A) Stays of commission actions.

5.29(1) *When available.*

a. Any party to a contested case proceeding may petition the college student aid commission for a stay of an order issued in that proceeding or for other temporary remedies, pending review by the commission. The petition shall be filed with the notice of appeal and shall state the reasons justifying a stay or other temporary remedy. The commission may rule on the stay or authorize the presiding officer to do so.

b. Any party to a contested case proceeding may petition the college student aid commission for a stay or other temporary remedies pending judicial review, of all or part of that proceeding. The petition shall state the reasons justifying a stay or other temporary remedy.

5.29(2) *When granted.* In determining whether to grant a stay, the presiding officer or commission shall consider the factors listed in Iowa Code section 17A.19(5c).

5.29(3) *Vacation.* A stay may be vacated by the issuing authority upon application of the college student aid commission or any other party.

283—5.30(17A) No factual dispute contested cases. If the parties agree that no dispute of material fact exists as to a matter that would be a contested case if such a dispute of fact existed, the parties may present all relevant admissible evidence either by stipulation or otherwise as agreed by the parties, without necessity for the production of evidence at an evidentiary hearing. If such agreement is reached, a jointly submitted schedule detailing the method and timetable for submission of the record, briefs and oral argument should be submitted to the presiding officer for approval as soon as practicable. If the parties cannot agree, any party may file and serve a motion for summary judgment pursuant to the rules governing such motions.

283—5.31(17A) Emergency adjudicative proceedings.

5.31(1) Necessary emergency action. To the extent necessary to prevent or avoid immediate danger to the public health, safety, or welfare, and consistent with the Constitution and other provisions of law, the commission may issue a written order in compliance with Iowa Code section 17A.18 to suspend a license in whole or in part, order the cessation of any continuing activity, order affirmative action, or take other action within the jurisdiction of the commission by emergency adjudicative order. Before issuing an emergency adjudicative order, the commission shall consider factors including, but not limited to, the following:

- a. Whether there has been a sufficient factual investigation to ensure that the commission is proceeding on the basis of reliable information;
- b. Whether the specific circumstances which pose immediate danger to the public health, safety or welfare have been identified and determined to be continuing;
- c. Whether the person required to comply with the emergency adjudicative order may continue to engage in other activities without posing immediate danger to the public health, safety or welfare;
- d. Whether imposition of monitoring requirements or other interim safeguards would be sufficient to protect the public health, safety or welfare; and
- e. Whether the specific action contemplated by the commission is necessary to avoid the immediate danger.

5.31(2) Issuance of order.

- a. An emergency adjudicative order shall contain findings of fact, conclusions of law, and policy reasons to justify the determination of an immediate danger in the commission's decision to take immediate action.
- b. The written emergency adjudicative order shall be immediately delivered to persons who are required to comply with the order by utilizing one or more of the following procedures:
 - (1) Personal delivery;
 - (2) Certified mail, return receipt requested, to the last address on file with the commission;
 - (3) Certified mail to the last address on file with the commission;
 - (4) First-class mail to the last address on file with the commission; or
 - (5) Fax. Fax may be used as the sole method of delivery if the person required to comply with the order has filed a written request that commission orders be sent by fax and has provided a fax number for that purpose.
- c. To the degree practicable, the commission shall select the procedure for providing written notice that best ensures prompt, reliable delivery.

5.31(3) Oral notice. Unless the written emergency adjudicative order is provided by personal delivery on the same day that the order issues, the commission shall make reasonable immediate efforts to contact by telephone the persons who are required to comply with the order.

5.31(4) Completion of proceedings. After the issuance of an emergency adjudicative order, the commission shall proceed as quickly as feasible to complete any proceedings that would be required if the matter did not involve an immediate danger.

Issuance of a written emergency adjudicative order shall include notification of the date on which commission proceedings are scheduled for completion. After issuance of an emergency adjudicative

order, continuance of further commission proceedings to a later date will be granted only in compelling circumstances upon application in writing.

These rules are intended to implement Iowa Code chapter 17A.

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CHAPTER 24
RURAL IOWA PRIMARY CARE LOAN REPAYMENT PROGRAM

283—24.1(261) Rural Iowa primary care loan repayment program. The rural Iowa primary care loan repayment program is a state-supported and administered loan repayment program for students who agree to practice as physicians in service commitment areas for five consecutive years and meet the requirements of these rules.

[ARC 1320C, IAB 2/19/14, effective 3/26/14; ARC 1685C, IAB 10/29/14, effective 12/3/14]

283—24.2(261) Definitions. As used in this chapter:

“Eligible loan” means the physician’s total subsidized, unsubsidized, and consolidated Federal Stafford Loan amount under the Federal Family Education Loan Program, Federal Direct Loan Program, federal Graduate PLUS Loan, or federal Perkins Loan, including principal and interest. Only the outstanding portion of a federal consolidation loan that was used to repay an eligible subsidized or unsubsidized Federal Stafford Loan qualifies for loan repayment.

“Eligible university” means either the State University of Iowa Carver College of Medicine or Des Moines University College of Osteopathic Medicine.

“Maximum award” means the maximum amount of loan repayments that the physician can receive after completing all obligations under the rural Iowa primary care loan repayment program, not to exceed a total of \$200,000. The maximum award can be applied only to eligible loans; thus, payments cannot exceed the outstanding eligible loan balance at the time of payment.

“Physician” means an individual who holds a practitioner’s license issued by an agency or board under the Iowa department of public health and is employed in the practice of medicine and surgery or osteopathic medicine and surgery, specializing in family medicine, pediatrics, psychiatry, internal medicine, or general surgery.

“Residency program” means an accredited medical residency program located in the state of Iowa in which the residency is physically performed in the state of Iowa.

“Service commitment area” means a medically underserved Iowa city with a population of less than 26,000 that is located more than 20 miles from a city with a population of 50,000 or more. Each physician participating in the program must contract with the service commitment area to ensure the service commitment area provides a nonrefundable \$20,000 contribution for deposit in the rural Iowa primary care trust fund. Payment of the nonrefundable contribution to the trust fund can be made by, but is not limited to, the following organizations: community agencies, hospitals, medical groups, municipalities, community foundations, local government entities, or other community entities. Locations and distances between cities will be consistently measured and verified by calculating the straight-line distance between main post offices.

[ARC 1320C, IAB 2/19/14, effective 3/26/14; ARC 1685C, IAB 10/29/14, effective 12/3/14]

283—24.3(261) Eligibility requirements.

24.3(1) An eligible university will recommend up to ten applicants to the commission for loan repayment benefits. Priority will be given to students who are Iowa residents upon enrolling in the eligible university. The criteria used by the state board of regents to determine residency for tuition purposes, Iowa Administrative Code rule 681—1.4(262), are adopted for this program. The percentage of the agreements to be entered into by students attending each eligible university shall be evenly divided.

a. The commission will annually determine and communicate the number of recommendations that can be funded at each eligible university.

b. If fewer than the recommendations in 24.3(1)“*a*” are fulfilled by students at one eligible university, the commission may obtain additional recommendations from the other eligible university to award the remaining agreements.

24.3(2) An applicant must enter into an agreement with the commission during the applicant’s final year of study leading to a doctor of medicine or osteopathy degree.

24.3(3) An applicant must be enrolled on a full-time basis and graduate with a doctor of medicine or osteopathy degree from an eligible university. The commission may waive the full-time enrollment requirement for a temporary time frame only in the instance of a leave of absence approved by an eligible university. The applicant must request a waiver from the commission in writing.

24.3(4) An applicant must apply for, enter, and complete a residency program in Iowa.

24.3(5) Within nine months of graduating from the residency program, an applicant must receive a permanent license to practice medicine and surgery or osteopathic medicine and surgery in the state of Iowa and engage in full-time practice, as defined by the service commitment area, of medicine and surgery or osteopathic medicine and surgery specializing in family medicine, pediatrics, psychiatry, internal medicine, or general surgery for a period of five consecutive years in a service commitment area.

24.3(6) An applicant must annually complete and return to the commission an affidavit of acceptance into and completion of residency programs and acceptance of and completion of employment obligations in a service commitment area.

24.3(7) Prior to or upon engagement in full-time employment in a service commitment area, the physician must contract with a service commitment area to provide a nonrefundable \$20,000 contribution for deposit in the rural Iowa primary care trust fund. Payment must be received by the commission from a service commitment area prior to payment of any loan repayment awards.

24.3(8) Failure by the applicant to meet all eligibility requirements under this rule and in the agreement will result in forfeiture of all remaining unpaid payments.

[ARC 1320C, IAB 2/19/14, effective 3/26/14; ARC 1685C, IAB 10/29/14, effective 12/3/14]

283—24.4(261) Awarding of funds.

24.4(1) Prior to accepting an offer of employment, the physician must notify the commission of the service commitment area in which the physician will be employed, and the commission will verify the eligibility of the service commitment area.

24.4(2) The maximum award will be paid to the physician's eligible loan holder in five equal installments, upon successful completion of each of five 12-month employment obligations. Failure to complete all, or any portion, of the five-consecutive-year employment obligation will result in the forfeiture of all remaining unpaid payments. A physician who fails to meet the requirements of these rules may also be subject to repayment of moneys advanced by the service commitment area as provided in any contract between the physician and the service commitment area.

24.4(3) No loan repayment amounts will be paid until the service commitment area provides the nonrefundable \$20,000 contribution for deposit into the rural Iowa primary care trust fund.

[ARC 1320C, IAB 2/19/14, effective 3/26/14; ARC 1685C, IAB 10/29/14, effective 12/3/14]

283—24.5(261) Waivers.

24.5(1) *Service commitment area.* The commission may waive the requirement that the physician practice in the same service commitment area for five years. The physician must request a waiver from the commission in writing.

24.5(2) *Full-time employment.* The commission may waive the requirement that the physician be employed full-time if the physician demonstrates exceptional circumstances. The physician must request a waiver from the commission in writing. If a waiver request is granted by the commission, the agreement will be amended to provide an allowance for part-time employment. The five-year employment obligation will be proportionally extended to ensure the physician is employed in a service commitment area for the equivalent of five full-time years.

24.5(3) *Postponement of physician employment.* The physician obligation to engage in practice in accordance with 24.3(5) may be postponed for no more than two years from the time full-time practice was to commence. The physician must request a waiver from the commission in writing for one of the following purposes:

- a. Active duty service in the armed forces, the armed forces military reserve, or the national guard.
- b. Service in Volunteers in Service to America or the federal Peace Corps.
- c. A service commitment to the United States Public Health Service Commissioned Corps.

d. A period of religious missionary work conducted by an organization exempt from federal income taxation pursuant to Section 501(c)(3) of the Internal Revenue Code.

The physician obligation to engage in practice in accordance with 24.3(5) may be postponed for a period exceeding two years for any period of temporary medical incapacity, including leave approved under the Family and Medical Leave Act, during which the physician is unable to engage in full-time practice. The physician must request a waiver from the commission in writing.

24.5(4) *Satisfaction of physician employment.* All obligations under the rural Iowa primary care loan repayment program are considered to be satisfied when any of the following conditions are met:

- a. All terms of the agreement are met.
- b. The person who entered into the agreement dies.
- c. The person who entered into the agreement, due to permanent disability, is unable to meet the requirements of these rules.
- d. The person who entered into the agreement has no remaining eligible loan balance to repay.

[ARC 1320C, IAB 2/19/14, effective 3/26/14; ARC 1685C, IAB 10/29/14, effective 12/3/14]

283—24.6(261) Loan repayment cancellation.

24.6(1) Within 30 days following withdrawal from an eligible university, or termination of employment from a residency program or as a physician in a service commitment area, the applicant must notify the commission.

24.6(2) The applicant is responsible for notifying the commission immediately of a change in contact information including, but not limited to, name, telephone number, e-mail address, and place of employment.

[ARC 1320C, IAB 2/19/14, effective 3/26/14]

283—24.7(261) Restrictions. A physician who is in default on a Federal Stafford Loan, Grad PLUS Loan, SLS Loan, Perkins/National Direct/National Defense Student Loan, Health Professions Student Loan (HPSL), or Health Education Assistance Loan (HEAL) or who owes a repayment on any Title IV grant assistance or state award shall be ineligible for loan repayment. Eligibility may be reinstated upon payment in full of the delinquent obligation or by commission ruling on the basis of adequate extenuating evidence presented in appeal under the procedures set forth in 283—Chapters 4 and 5.

[ARC 1320C, IAB 2/19/14, effective 3/26/14]

These rules are intended to implement Iowa Code section 261.113 as amended by 2014 Iowa Acts, Senate File 2347.

[Filed ARC 1320C (Notice ARC 1121C, IAB 10/16/13), IAB 2/19/14, effective 3/26/14]

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CHAPTER 25
RURAL IOWA ADVANCED REGISTERED NURSE PRACTITIONER AND
PHYSICIAN ASSISTANT LOAN REPAYMENT PROGRAM

283—25.1(261) Rural Iowa advanced registered nurse practitioner and physician assistant loan repayment program. The rural Iowa advanced registered nurse practitioner and physician assistant loan repayment program is a state-supported and administered loan repayment program for applicants who agree to practice as advanced registered nurse practitioners or physician assistants in service commitment areas for five consecutive years and meet the requirements of these rules.
[ARC 1321C, IAB 2/19/14, effective 3/26/14; ARC 1686C, IAB 10/29/14, effective 12/3/14]

283—25.2(261) Definitions. As used in this chapter:

“Advanced registered nurse practitioner” means an individual who graduated from a graduate-level credential program at an eligible university, holds a practitioner’s license to practice as an advanced registered nurse practitioner pursuant to Iowa Code chapter 152, and is employed in the practice of nursing in an eligible service commitment area.

“Eligible loan” means the advanced registered nurse practitioner’s or physician assistant’s total subsidized, unsubsidized, and consolidated Federal Stafford Loan amount under the Federal Family Education Loan Program, Federal Direct Loan Program, federal Graduate PLUS Loan, or federal Perkins Loan, including principal and interest. Only the outstanding portion of a federal consolidation loan that was used to repay an eligible subsidized or unsubsidized Federal Stafford Loan qualifies for loan repayment.

“Eligible university” means a college or university that meets the requirements of Iowa Code section 261.2, subsection 11, and is an institution of higher learning under the control of the state board of regents or an accredited private institution as defined in Iowa Code section 261.9. An eligible university must complete and return the forms to the commission to participate in the program.

“Maximum award” means the maximum amount of loan repayments that the advanced registered nurse practitioner or physician assistant can receive after completing all obligations under the rural Iowa advanced registered nurse practitioner and physician assistant loan repayment program, not to exceed a total of \$20,000. The maximum award can be applied only to eligible loans; thus, payments cannot exceed the outstanding eligible loan balance at the time of payment.

“Physician assistant” means an individual who graduated with a master’s degree in a physician assistant studies program at an eligible university, holds a practitioner’s license to practice as a physician assistant pursuant to Iowa Code chapter 148C, and is employed as a physician assistant in an eligible service commitment area.

“Service commitment area” means a medically underserved Iowa city with a population of less than 26,000 that is located more than 20 miles from a city with a population of 50,000 or more. Each applicant participating in the program must contract with the service commitment area to ensure the service commitment area provides a nonrefundable \$2,000 contribution for deposit in the rural Iowa advanced registered nurse practitioner and physician assistant trust fund. Payment of the nonrefundable contribution to the trust fund can be made by, but is not limited to, the following organizations: community agencies, hospitals, medical groups, municipalities, community foundations, local government entities, or other community entities. Locations and distances between cities will be consistently measured and verified by calculating the straight-line distance between main post offices.

“Surplus funds” means funding available after the maximum award has been obligated to all recommended applicants in accordance with rule 283—25.3(261).

[ARC 1321C, IAB 2/19/14, effective 3/26/14; ARC 1686C, IAB 10/29/14, effective 12/3/14]

283—25.3(261) Eligibility requirements.

25.3(1) The commission will annually determine and communicate the number of physician assistant and advanced registered nurse practitioner recommendations that can be funded at each eligible university. The intent of this determination will be to ensure that an equal number of students in each program at eligible universities are able to enter into an agreement. Priority will be given to applicants

who are Iowa residents upon enrolling in the eligible university. The criteria used by the state board of regents to determine residency for tuition purposes, Iowa Administrative Code rule 681—1.4(262), are adopted for this program. If fewer than the maximum number of physician assistants or advanced registered nurse practitioners are recommended at an eligible university, the commission may obtain additional recommendations from the other eligible universities to award the remaining agreements.

25.3(2) An applicant must enter into an agreement with the commission during the applicant's final year of study leading to eligibility for licensure as an advanced registered nurse practitioner or physician assistant.

25.3(3) An applicant must be enrolled on a full-time basis and graduate from an eligible university with a graduate-level credential that qualifies the applicant to work as a physician assistant or advanced registered nurse practitioner. The commission may waive the full-time enrollment requirement for a temporary time frame only in the instance of a leave of absence approved by an eligible university. The applicant must request a waiver from the commission in writing.

25.3(4) Within nine months of graduating from an eligible university, an applicant must receive a permanent license to practice nursing or to work as a physician assistant in the state of Iowa and engage in full-time practice, as defined by the service commitment area, as an advanced registered nurse practitioner or physician assistant for a period of five consecutive years in a service commitment area.

25.3(5) An applicant must annually complete and return to the commission an affidavit of completion of the employment obligation in a service commitment area.

25.3(6) Prior to or upon engagement in full-time employment in a service commitment area, the advanced registered nurse practitioner or physician assistant must contract with the service commitment area to provide a nonrefundable \$2,000 contribution for deposit in the rural Iowa advanced registered nurse practitioner and physician assistant trust fund. Payment must be received by the commission from the service commitment area prior to payment of any loan repayment awards to the advanced registered nurse practitioner or physician assistant.

25.3(7) Failure by the applicant to meet all eligibility requirements under these rules and in the agreement will result in forfeiture of all remaining unpaid payments.

[ARC 1321C, IAB 2/19/14, effective 3/26/14; ARC 1686C, IAB 10/29/14, effective 12/3/14]

283—25.4(261) Awarding of funds.

25.4(1) Prior to accepting an offer of employment, the advanced registered nurse practitioner or physician assistant must notify the commission of the service commitment area in which the advanced registered nurse practitioner or physician assistant will be employed, and the commission will verify the eligibility of the service commitment area.

25.4(2) The maximum award will be paid to the advanced registered nurse practitioner's or physician assistant's eligible loan lender in five equal installments, upon successful completion of each of the five 12-month employment obligations. Failure to complete all, or any portion, of the five-consecutive-year employment obligation will result in the forfeiture of all remaining unpaid payments. An advanced registered nurse practitioner or physician assistant who fails to meet the requirements of these rules may also be subject to repayment of moneys advanced by the service commitment area as provided in any contract between the advanced registered nurse practitioner or physician assistant and the service commitment area.

25.4(3) No loan repayment amounts will be paid until the service commitment area provides the nonrefundable \$2,000 contribution for deposit into the rural Iowa advanced registered nurse practitioner and physician assistant trust fund.

25.4(4) If surplus funds are available, the commission will accept applications from physician assistants and advanced registered nurse practitioners practicing full-time in service commitment areas. Recipient selections shall be evenly divided between physician assistants and advanced registered nurse practitioners, to the extent possible. If surplus funds are not sufficient to fund all applicants, physician assistant and advanced registered nurse practitioner applicants will be prioritized by Iowa residency status, full-time employment status, individuals working in a federally designated Health Professional Shortage Area (HPSA) or a Governor's Designated Rural Health Clinic county, total eligible student

loan debt (highest receiving priority), and application date (earliest submitted receiving priority). Recipients will enter into agreements with the commission, and payments will be made in accordance with subrules 25.4(2) and 25.4(3).

[ARC 1321C, IAB 2/19/14, effective 3/26/14; ARC 1686C, IAB 10/29/14, effective 12/3/14]

283—25.5(261) Waivers.

25.5(1) *Service commitment area.* The commission may waive the requirement that the advanced registered nurse practitioner or physician assistant practice in the same service commitment area for five years. The advanced registered nurse practitioner or physician assistant must request a waiver from the commission in writing.

25.5(2) *Full-time employment.* The commission may waive the requirement that the advanced registered nurse practitioner or physician assistant be employed full-time if the advanced registered nurse practitioner or physician assistant demonstrates exceptional circumstances. The advanced registered nurse practitioner or physician assistant must request a waiver from the commission in writing. If a waiver request is granted by the commission, the agreement will be amended to provide an allowance for part-time employment. The five-year employment obligation will be proportionally extended to ensure the advanced registered nurse practitioner or physician assistant is employed in a service commitment area for the equivalent of five full-time years.

25.5(3) *Postponement of advanced registered nurse practitioner or physician assistant employment.* The advanced registered nurse practitioner or physician assistant obligation to engage in practice in accordance with 25.3(4) may be postponed for no more than two years from the time full-time practice was to commence. The advanced registered nurse practitioner or physician assistant must request a waiver from the commission in writing for one of the following purposes:

- a. Active duty service in the armed forces, the armed forces military reserve, or the national guard.
- b. Service in Volunteers in Service to America or the federal Peace Corps.
- c. A service commitment to the United States Public Health Service Commissioned Corps.
- d. A period of religious missionary work conducted by an organization exempt from federal income taxation pursuant to Section 501(c)(3) of the Internal Revenue Code.

The advanced registered nurse practitioner or physician assistant obligation to engage in practice in accordance with 25.3(4) may be postponed for a period exceeding two years for any period of temporary medical incapacity, including leave approved under the Family and Medical Leave Act, during which the advanced registered nurse practitioner or physician assistant is unable to engage in full-time practice. The advanced registered nurse practitioner or physician assistant must request a waiver from the commission in writing.

25.5(4) *Satisfaction of advanced registered nurse practitioner or physician assistant employment.* All obligations under the rural Iowa advanced registered nurse practitioner and physician assistant loan repayment program are considered to be satisfied when any of the following conditions are met:

- a. All terms of the agreement are met.
- b. The person who entered into the agreement dies.
- c. The person who entered into the agreement, due to permanent disability, is unable to meet the requirements of these rules.
- d. The person who entered into the agreement has no remaining eligible loan balance to repay.

[ARC 1321C, IAB 2/19/14, effective 3/26/14; ARC 1686C, IAB 10/29/14, effective 12/3/14]

283—25.6(261) Loan repayment cancellation.

25.6(1) Within 30 days following withdrawal from an eligible university, or termination of employment from a residency program or as an advanced registered nurse practitioner or physician assistant in a service commitment area, the applicant must notify the commission.

25.6(2) The applicant is responsible for notifying the commission immediately of a change in contact information including, but not limited to, name, telephone number, e-mail address, and place of employment.

[ARC 1321C, IAB 2/19/14, effective 3/26/14]

283—25.7(261) Restrictions. An advanced registered nurse practitioner or physician assistant who is in default on a Federal Stafford Loan, Grad PLUS Loan, SLS Loan, Perkins/National Direct/National Defense Student Loan, Health Professions Student Loan (HPSL), or Health Education Assistance Loan (HEAL) or who owes a repayment on any Title IV grant assistance or state award shall be ineligible for loan repayment. Eligibility may be reinstated upon payment in full of the delinquent obligation or by commission ruling on the basis of adequate extenuating evidence presented in appeal under the procedures set forth in 283—Chapters 4 and 5.

[ARC 1321C, IAB 2/19/14, effective 3/26/14]

These rules are intended to implement Iowa Code section 261.114 as amended by 2014 Iowa Acts, Senate File 2347.

[Filed ARC 1321C (Notice ARC 1120C, IAB 10/16/13), IAB 2/19/14, effective 3/26/14]

[Filed ARC 1686C (Notice ARC 1587C, IAB 8/20/14), IAB 10/29/14, effective 12/3/14]

HUMAN SERVICES DEPARTMENT[441]

Rules transferred from Social Services Department[770] to Human Services Department[498],
see 1983 Iowa Acts, Senate File 464, effective July 1, 1983.

Rules transferred from agency number [498] to [441] to conform with the reorganization
numbering scheme in general, IAC Supp. 2/11/87.

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[Ch 7, July 1973 IDR Supplement, renumbered as Ch 81]

[Prior to 7/1/83, Social Services[770] Ch 7]

[Prior to 2/11/87, Human Services[498]]

PREAMBLE

This chapter applies to contested case proceedings conducted by or on behalf of the department. The definitions in rule 441—7.1(17A) apply to the rules in both Division I and Division II of Chapter 7.
[ARC 1206C, IAB 12/11/13, effective 1/15/14]

441—7.1(17A) Definitions.

“Administrative hearing” means a type of hearing that an appellant may elect in which the presiding officer reviews the written record only and makes a decision based on the facts available within the appeal file. An administrative hearing does not require an in-person or teleconference hearing. The final determination to establish whether an administrative hearing may be held will be made by the appeals section or the presiding officer.

“Administrative law judge” means an employee of the department of inspections and appeals who conducts appeal hearings.

“Agency” means the Iowa department of human services, including any of its local, institutional, or central administrative offices.

“Aggrieved person” means a person against whom the department has taken an adverse action. This includes a person who meets any of the following conditions:

1. For financial assistance (including the family investment program, refugee cash assistance, child care assistance, emergency or disaster assistance, family or community self-sufficiency grants, family investment program hardship exemptions, and state supplementary assistance dependent person, in-home health related care, and residential care facility benefits), a person:

- Whose request to be given an application was denied.
- Whose application for assistance has been denied or has not been acted on in a timely manner.
- Who contests the effective date of assistance.
- Who contests the amount of benefits granted.
- Who has been notified that there will be a reduction or cancellation of assistance.
- Who has been notified that an overpayment of benefits has been established and repayment is requested.

2. For food assistance, a person:

- Whose request to be given an application was denied.
- Whose application has been denied or has not been acted on in a timely manner.
- Who contests the effective date of assistance.
- Who contests the amount of benefits granted.
- Who has been notified that there will be a reduction or cancellation of benefits.
- Whose request to receive a credit for benefits from an electronic benefit transfer (EBT) account has been denied.
- Who has been notified that an overpayment of benefits has been established and repayment is requested.

3. For medical assistance, healthy and well kids in Iowa, IowaCare, the Iowa Health and Wellness Plan, family planning services, and waiver services, a person (see numbered paragraph “7” for providers):

- Whose request to be given an application was denied.
- Whose application has been denied or has not been acted on in a timely manner.
- Whose eligibility has been terminated, suspended or reduced.
- Who has been notified that there will be a reduction in the level of benefits or services the person is eligible to receive.

- Who has received a determination of the amount of medical expenses that must be incurred to establish income eligibility for the medically needy program or a determination of income for the purposes of imposing any premiums, enrollment fees or cost sharing.

- Who has been notified that the level of services provided by a nursing facility is not needed based on a preadmission screening and resident review (PASRR) evaluation.

- Who has been notified that level of care requirements have not been met.

- Who has been aggrieved by a failure to take into account the appellant's choice in assignment to a coverage group.

- Who contests the effective date of assistance or services.

- Who contests the amount or effective date of health insurance premium payments, healthy and well kids in Iowa premium payments, Medicaid for employed people with disabilities premium payments, IowaCare premium payments, or the spenddown amount under the medically needy program.

- Who contests the amount of client participation.

- Whose claim for payment or prior authorization has been denied.

- Who has been notified that the reconsideration process has been exhausted and who remains dissatisfied with the outcome.

- Who has received notice from the medical assistance hotline that services not received or services for which an individual is being billed are not payable by medical assistance.

- Who has been notified that an overpayment of benefits has been established and repayment is requested.

- Who has been denied requested nonemergency medical transportation services by the broker designated by the department pursuant to rule 441—78.13(249A) and has exhausted the grievance procedures established by the broker pursuant to 441—subrule 78.13(7).

4. For social services, including, but not limited to, adoption, foster care, and family-centered services, a person (see numbered paragraph “7” for providers):

- Whose request to be given an application was denied.

- Whose application for services or payment for adoption subsidy or foster care has been denied or has not been acted on in a timely manner.

- For whom it is determined that the person must participate in a service program.

- Whose claim for payment of services has been denied.

- Who has been notified that a protective or vendor payment will be established.

- Who has been notified that there will be a reduction or cancellation of services.

- Who has been notified that an overpayment of services has been established and repayment is requested.

- Who applies for an adoption subsidy after the adoption has been finalized.

- Who alleges that the adoptive placement of a child has been denied or delayed when an adoptive family is available outside the jurisdiction with responsibility for handling the child's case.

- Who has not been referred to community care as provided in rule 441—186.2(234).

- Who has been referred to community care as provided in rule 441—186.2(234) and has exhausted the community care provider's dispute resolution process.

- Who has been referred to aftercare services under 441—Chapter 187 and has exhausted the aftercare provider's dispute resolution process.

5. For child support recovery, a person:

- Who is not entitled to a support payment in full or in part because of the date of collection, as provided under rule 441—95.13(17A), or whose dispute based on the date of collection has not been acted on in a timely manner.

- Who is contesting a claim or offset as provided in 441—subrule 95.6(3), 95.7(8), or 98.81(3) by alleging a mistake of fact. “Mistake of fact” means a mistake in the identity of the obligor or whether the delinquency meets the criteria for referral or submission. The issue on appeal shall be limited to a mistake of fact. Any other issue may be determined only by a court of competent jurisdiction.

- Whose name has been certified for passport sanction as provided in Iowa Code section 252B.5.

- Who has been notified that there will be a termination in services as provided in rule 441—95.14(252B).

6. For PROMISE JOBS, a person:

- Whose claim for participation allowances has been denied, reduced, or canceled.
- Who claims that the contents of the family investment agreement are not sufficient or necessary for the family to reach self-sufficiency.

- Who is dissatisfied with the results of informal grievance resolution procedures, or who fails or refuses to receive informal grievance resolution procedures.

- Who has been notified that PROMISE JOBS services will be canceled due to imposition of a limited benefit plan.

- Who has been notified that an overpayment of benefits has been established and repayment is requested.

- Who alleges acts of discrimination on the basis of race, creed, color, sex, age, physical or mental disability, religion, national origin, or political belief.

- Who claims displacement by a PROMISE JOBS participant.

7. For providers, a person or entity:

- Whose license, certification, registration, approval, or accreditation has been denied or revoked or has not been acted on in a timely manner.

- Whose claim for payment or request for prior authorization of payment has been denied in whole or in part and who states that the denial was not made according to department policy. Providers of Medicaid services must accept reimbursement based on the department's methodology.

- Whose contract as a Medicaid patient manager has been terminated.

- Who has been subject to the withholding of a payment to recover a prior overpayment or who has received an order to repay an overpayment pursuant to 441—subrule 79.4(7).

- Who has been notified that the managed care reconsideration process has been exhausted and who remains dissatisfied with the outcome.

- Whose application for child care quality rating has not been acted upon in a timely fashion, who disagrees with the department's quality rating decision, or whose certificate of quality rating has been revoked.

- Who has been subject to an adverse action related to the Iowa electronic health record incentive program pursuant to rule 441—79.16(249A).

- Who, as a managed care organization (MCO) provider or Iowa plan contractor when acting on behalf of a member, has a dispute regarding payment of claims.

- Who has been notified that an application or reapplication for licensure was issued as a provisional license.

- Who has been notified that a license has been issued for a limited time.

8. For the child or dependent adult abuse registry, juvenile sex offender registry or criminal record check evaluation, a person:

- Who is a person alleged responsible for child abuse.

- Who has requested correction of dependent adult abuse information.

- Who has been restricted from or denied employment in a health care facility, state institution, or other facility based on a record check. "Employment" includes, but is not limited to, service as an employee, a volunteer, a provider, or a contractor. "Facilities" include, but are not limited to, county or multicounty juvenile detention homes and juvenile shelter care homes, child-placing agencies, substance abuse treatment programs, group living foster care facilities, child development homes, child care centers, state resource centers, mental health institutes, and state training schools.

- Who is contesting a risk assessment decision as provided in rule 441—103.34(692A) by alleging that the risk assessment factors have not been properly applied, the information relied upon to support the assessment findings is inaccurate, or the procedures were not correctly followed.

9. For mental health and disability services, a person:

- Whose application for state payment under 441—Chapter 153, Division IV, has been denied or has not been acted upon in a timely manner.

- Who has been notified that there will be a reduction or cancellation of services under the state payment program.
- Whose request to be given an application was denied.
- Whose eligibility has been terminated, suspended or reduced.
- Who has been notified that there will be a reduction in the level of benefits or services the person is eligible to receive.
- Who contests the effective date of assistance or services.
- Who has been notified that the reconsideration process has been exhausted and who remains dissatisfied with the outcome.
- Who contests the amount or effective date of cost-sharing requirements for the autism support program.
- Whose service authorization requests for applied behavioral analysis services have been denied or reduced.

10. For HIPAA (Health Insurance Portability and Accountability Act) decisions, a current or former applicant or recipient of Medicaid or HAWK-I, or a person currently or previously in a department facility whose request:

- To restrict use or disclosure of protected health information was denied.
- To change how protected health information is provided was denied.
- For access to protected health information was denied. When the denial is subject to reconsideration under 441—paragraph 9.9(1) “i,” persons denied access due to a licensed health care professional’s opinion that the information would constitute a danger to that person or another person must first exhaust the reconsideration process.
- To amend protected health information was denied.
- For an accounting of disclosures was denied.

11. For drug manufacturers, a manufacturer that has received a notice of decision regarding disputed drug rebates pursuant to the dispute resolution procedures of a national drug rebate agreement or an Iowa Medicaid supplemental drug rebate agreement.

12. Bidders that have participated in a competitive procurement bid process. Appeals resulting from a competitive procurement bid process will be handled pursuant to Chapter 7, Division II.

13. Individuals and providers that are not listed in paragraphs “1” to “12” may meet the definition of an aggrieved person if the department has taken an adverse action against that individual or provider.

“*Appeal*” denotes a review and hearing request made by a person who is affected by a decision made by the agency or its designee. An appeal shall be considered a contested case within the meaning of Iowa Code chapter 17A.

“*Appeals advisory committee*” means a committee consisting of central office staff who represent the department in the screening of proposed decisions for the director.

“*Appeals section*” means the unit within the department of human services that receives appeal requests, certifies requests for hearing, and issues final appeal decisions.

“*Appellant*” denotes the person who claims or asserts a right or demand or the party who takes an appeal from a hearing to an Iowa district court.

“*Attribution appeal*” means an appeal to determine if additional resources can be allocated for the community spouse when the other spouse has entered a medical institution or is applying for home-and community-based waiver services. The result of the attribution appeal may affect Medicaid eligibility. An appellant may elect to have an attribution appeal held by administrative hearing.

“*Authorized representative*” means a person or organization designated by an appellant to act on the appellant’s behalf or who has legal authority to act on behalf of the appellant, such as a guardian or power of attorney.

“*Bidder*” means an individual or entity that submits a proposal in response to a competitive procurement issued by the department.

“*Contested case*” means a proceeding defined by Iowa Code section 17A.2(5) and includes any matter defined as a “no factual dispute” contested case under Iowa Code section 17A.10A.

“*Department*” means the Iowa department of human services.

“Department of inspections and appeals” means the state agency that contracts with the department to conduct appeal hearings.

“Director” means the director of the department of human services or the director’s designee.

“Due process” denotes the right of a person affected by an agency decision to receive a notice of decision or notice of action and an opportunity to be heard at an appeal hearing and to present an effective defense.

“Electronic account” means a Web-based account established by the department for an applicant or member for communication between the department and the applicant or member.

“Electronic case record” means an electronic file that includes all information collected and generated by the department regarding each individual’s Medicaid or healthy and well kids in Iowa eligibility and enrollment, including all documentation required for eligibility and any information collected or generated as part of a fair hearing process conducted by the department or through the exchange appeals process.

“Ex parte communication” means written, oral, or other forms of communication between a party to the appeal and the presiding officer while an appeal is pending when all parties were not given the opportunity to participate.

“Exchange” means an American health benefit exchange established pursuant to Section 1311 of the Patient Protection and Affordable Care Act of 2010 (Pub. L. 111-148). This entity makes qualified health plans available to qualified individuals and qualified employers.

“Food assistance administrative disqualification hearing” means a type of hearing used to determine if an individual fraudulently received benefits for which the individual was not eligible. A presiding officer shall determine if the individual will be banned from participating in the food assistance program for a period of time.

“Group hearings” denotes an opportunity for two or more persons to present their case jointly when all have the same complaint against agency policy.

“Informal conference” means a type of meeting between the appellant and the appellant’s representative, unless precluded by federal law or state statute, and a representative of the department. The purpose of the informal conference is to provide information as to the reasons for the intended adverse action, to answer questions, to explain the basis for the adverse action, to provide an opportunity for the appellant to explain the appellant’s action or position, and to provide an opportunity for the appellant to examine the contents of the case record, including any electronic case record, plus all documents and records to be used by the department at the hearing in accordance with 441—Chapter 9.

“In person or face-to-face hearing” means an appeal hearing conducted by an administrative law judge who is physically present in the same location as the appellant.

“Intentional program violation” means deliberately making a false or misleading statement; or misrepresenting, concealing, or withholding facts; or committing any act that is a violation of the Food and Nutrition Act of 2008, food assistance program regulations, or any state law relating to the use, presentation, transfer, acquisition, receipt, possession, or trafficking of an electronic benefit transfer (EBT) card. An intentional program violation is determined through a food assistance administrative disqualification hearing. The hearing may result in a period of ineligibility for the program, a claim for overpayment of benefits, or both.

“Local office” means the county, institution or district office of the department of human services.

“Party” means a party as defined in Iowa Code subsection 17A.2(8).

“Prehearing conference” means a type of meeting between the appellant and the appellant’s representative, unless precluded by federal law or state statute, a representative of the department and a presiding officer. The purpose of the prehearing conference is to discuss the appealed issue, to inquire as to the potential for voluntary settlement, to establish the hearing date, to establish the location of the hearing including whether the hearing will be by telephone or in person, and to discuss procedural matters relevant to the case.

“Presiding officer” means an administrative law judge employed by the department of inspections and appeals. The presiding officer may also be the department’s director or the director’s designee. The presiding officer has the authority to conduct appeal hearings and render proposed and final decisions.

“Presumption” denotes an inference as to the existence of a fact not known or drawn from facts that are known.

“PROMISE JOBS discrimination complaint” means any written complaint filed in accordance with the provisions of rule 441—7.8(17A) by a PROMISE JOBS participant or the participant’s representative which alleges that an adverse action was taken against the participant on the basis of race, creed, color, sex, national origin, religion, age, physical or mental disability, or political belief.

“PROMISE JOBS displacement grievance” means any written complaint filed with a PROMISE JOBS contractee by regular employees or their representatives that alleges that the work assignment of an individual under the PROMISE JOBS program violates any of the prohibitions against displacement of regular workers described in rule 441—93.17(239B).

“Proposed decision” means the presiding officer’s recommended findings of fact, conclusions of law, and decision and order in contested cases where the department did not preside.

“Reconsideration” means a review process that must be exhausted before an appeal hearing is granted. Such review processes include, but are not limited to, a reconsideration request through:

1. The Iowa Medicaid enterprise (IME) or its subcontractors,
2. The managed health care review committee,
3. A division or bureau within the department,
4. The mental health and disability services commission,
5. A licensed health care professional as specified in 441—paragraph 9.9(1) “i,” or
6. Any division or bureau within the department, from a bidder in a competitive procurement bid process.

Once the reconsideration process is complete, a notice of decision will be issued with appeal rights.

“Sent” means deposited in the mail with first-class postage or posted to an individual’s electronic account.

“Teleconference hearing” means an appeal hearing conducted by an administrative law judge over the telephone.

“Timely notice period” is the time from the date a notice is sent to the effective date of action. That period of time shall be at least ten calendar days, except in the case of probable fraud of a beneficiary. When probable fraud exists, “timely notice period” shall be at least five calendar days from the date a notice is sent.

“Vendor” means a provider of health care under the medical assistance program or a provider of services under a service program.

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441—7.2(17A) Application of rules. Rescinded IAB 7/29/09, effective 9/2/09.

DIVISION I

441—7.3(17A) Presiding officer. Appeal hearings shall be conducted by a presiding officer appointed by the department of inspections and appeals pursuant to Iowa Code section 10A.801. The presiding officer shall not be connected in any way with the previous actions or decisions on which the appeal is made. Nor shall the presiding officer be subject to the authority, direction, or discretion of any person who has prosecuted or advocated in connection with that case, the specific controversy underlying that case, or any pending factually related contested case or controversy involving the same parties.

441—7.4(17A) Notification of hearing procedures. Hearing procedures shall be published in the form of rules and shall be made available to all applicants, recipients, appellants, and other interested groups and individuals. Procedures for hearings shall be identified in the notice of hearing issued to all parties as provided in subrule 7.10(7).

7.4(1) Hearing procedures must be furnished in electronic and paper format and orally as appropriate. The procedures must be written in plain language and in a manner that is accessible:

a. To individuals who are limited English proficient through oral interpretation, written translations, and taglines in non-English languages indicating the availability of language services. The services shall be at no cost to the individual.

b. To individuals living with disabilities through the provision of auxiliary aids in accordance with the Americans with Disabilities Act and Section 504 of the Rehabilitation Act. The services shall be at no cost to the individual.

7.4(2) The department shall inform individuals of the availability of the services and how to access such services.

[ARC 1261C, IAB 1/8/14, effective 3/1/14]

441—7.5(17A) The right to appeal. Any person or group of persons may file an appeal with the department concerning any issue. The department shall determine whether a hearing shall be granted.

7.5(1) *When a hearing is granted.* A hearing shall be granted to any appellant when the right to a hearing is granted by state or federal law or Constitution, except as limited in subrules 7.5(2) and 7.5(4).

7.5(2) *When a hearing is not granted.* A hearing shall not be granted when:

a. One of the following issues is appealed:

- (1) The service is no longer available through the department.
- (2) Repayment of food assistance benefits as a result of trafficking has been requested on Form 470-4179, Notice of Food Assistance Trafficking Debt.
- (3) Payment for a medical claim has been made in accordance with the Medicaid payment schedule for the service billed.
- (4) Children have been removed from or placed in a specific foster care setting.
- (5) Children have not been placed with or have been removed from a preadoptive family.
- (6) A qualified provider or qualified entity has denied a person presumptive eligibility for Medicaid under 441—subrule 75.1(30), 75.1(40), or 75.1(44).
- (7) A qualified provider or qualified entity has determined a person to be presumptively eligible for Medicaid under 441—subrule 75.1(30), 75.1(40), or 75.1(44), but presumptive eligibility ends due to the person's failure to file an application.
- (8) Notice has been issued from the treasury offset program for a food assistance overpayment.
- (9) A rate determination has been reviewed under rule 441—152.3(234).
- (10) The maximum provider rate ceiling has been contested for child care assistance under 441—subrule 170.4(7).
- (11) The risk pool board has accepted or rejected an application for assistance from the risk pool fund or the tobacco settlement fund risk pool fund in whole or in part under rules 441—25.66(426B) and 441—25.77(78GA, ch1221).
- (12) The appellant has a complaint about child support recovery matters other than those described in numbered paragraph “5” of the definition of an aggrieved person in rule 441—7.1(17A). This includes collection of an annual fee for child support services as specified in Iowa Code chapter 252B.
- (13) The appellant has a complaint about a local office employee (when this is the only issue of the appeal).
- (14) A request for an exception to policy under 441—subrule 1.8(1) has been denied.
- (15) A final decision from a previous hearing with a presiding officer has been implemented.
- (16) The issue appealed is not eligible for further hearing based on the doctrine of issue preclusion.
- (17) The appeal involves patient treatment interventions outlined in the patient handbook of the civil commitment unit for sexual offenders.
- (18) An MCO provider or Iowa plan contractor fails to submit a document providing the member's approval of the request for appeal.
- (19) Notice was issued by the exchange regarding determination of eligibility for enrollment in a qualified health plan or for advance payment of the premium tax credit or cost-sharing reductions.

(20) Notice has been issued regarding the completion of a family assessment that indicates no determination of child abuse or neglect has been made and no information has been reported to the child abuse registry.

b. Either state or federal law requires automatic grant adjustment for classes of recipients. The director of the department shall decide whether to grant a hearing in these cases. When the reason for an individual appeal is incorrect grant computation in the application of these automatic adjustments, a hearing may be granted.

c. State or federal law or regulation provides for a different forum for appeals.

d. The appeal is filed prematurely as:

- (1) There is no adverse action by the department, or
- (2) The appellant has not exhausted the reconsideration process.

e. Upon review, it is determined that the appellant does not meet the criteria of an aggrieved person as defined in rule 441—7.1(17A).

f. The sole basis for denying, terminating or limiting assistance under 441—Chapter 47 or 441—Chapter 58 is that funds for the respective programs have been reduced, exhausted, eliminated or otherwise encumbered.

g. The appellant is an “aggrieved party” as defined in rule 441—22.1(225C) and is eligible for a compliance hearing with the mental health and developmental disabilities commission in accordance with rule 441—22.5(225C).

h. The issue appealed is moot.

i. The issue appealed has previously been determined in another appeal by the same appellant.

7.5(3) *Group hearings.* The department may respond to a series of individual requests for hearings by requesting the department of inspections and appeals to conduct a single group hearing in cases in which the sole issue involved is one of state or federal law or policy or change in state or federal law or policy. An appellant scheduled for a group hearing may withdraw and request an individual hearing.

7.5(4) *Time limit for granting hearing to an appeal.* Subject to the provisions of subrule 7.5(1), when an appeal is made, the granting of a hearing to that appeal shall be governed by the following timeliness standards:

a. General standards. In general, a hearing shall be held if the appeal is made within 30 days after official notification of an action or before the effective date of action. When the appeal is made more than 30 days but less than 90 days after notification, the director shall determine whether a hearing shall be granted.

(1) The director may grant a hearing if one or more of the following conditions existed:

1. There was a serious illness or death of the appellant or a member of the appellant’s family.
2. There was a family emergency or household disaster, such as a fire, flood, or tornado.
3. The appellant offers a good cause beyond the appellant’s control, which can be substantiated.
4. There was a failure to receive the department’s notification for a reason not attributable to the appellant. Lack of a forwarding address is attributable to the appellant. A hearing may be granted if an appellant provides proof that a forwarding address was not supplied due to fear of domestic violence, homelessness, or other good cause.

(2) The time in which to appeal an agency action shall not exceed 90 days. Appeals made more than 90 days after notification shall not be heard.

(3) The day after the official notice is sent is the first day of the period within which an appeal must be filed. When the time limit for filing falls on a holiday or a weekend, the time will be extended to the next workday.

b. Food assistance, Medicaid or healthy and well kids in Iowa standard. For appeals regarding food assistance, Medicaid or the healthy and well kids in Iowa program, a hearing shall be held if the appeal is made within 90 days after official notification of an action.

c. Offset standards. For appeals regarding state or federal tax or debtor offsets, a hearing shall be held if the appeal is made within 15 days after official notification of the action. Counties have 30 days to appeal offsets, as provided in 441—paragraph 14.4(1)“e.” When the appeal is made more than 15 days but less than 90 days after notification, the director shall determine whether a hearing shall be granted.

(1) The director may grant a hearing if one or more of the following conditions existed:

1. There was a serious illness or death of the appellant or a member of the appellant's family.
2. There was a family emergency or household disaster, such as a fire, flood, or tornado.
3. The appellant offers a good cause beyond the appellant's control, which can be substantiated.
4. There was a failure to receive the department's notification for a reason not attributable to the appellant. Lack of a forwarding address is attributable to the appellant. A hearing may be granted if an appellant provides proof that a forwarding address was not supplied due to fear of domestic violence, homelessness, or other good cause.

(2) The time in which to appeal an offset action shall not exceed 90 days. Appeals made more than 90 days after notification shall not be heard.

(3) The day after the official notice is sent is the first day of the period within which an appeal must be filed. When the time limit for filing falls on a holiday or a weekend, the time will be extended to the next workday.

d. Abuse standard.

(1) For appeals regarding dependent adult abuse, a hearing shall be held if the appeal is made within six months after official notification of the action as provided in Iowa Code section 235B.10.

(2) For appeals regarding child abuse, a hearing shall be held if the appeal is made by a person alleged responsible for the abuse within 90 days after official notification of the action as provided in Iowa Code section 235A.19. A subject of a child abuse report, other than the alleged person responsible for the abuse, may file a motion to intervene in the hearing within 10 calendar days after the appeal notification.

(3) The day after the official notice is sent is the first day of the period within which an appeal must be filed. When the time limit for filing falls on a holiday or a weekend, the time will be extended to the next workday.

e. Displacement and discrimination standard. PROMISE JOBS displacement and discrimination appeals shall be granted hearing on the following basis:

(1) An appeal of an informal grievance resolution on a PROMISE JOBS displacement grievance shall be made in writing within 10 days of issuance (i.e., mailing) of the resolution decision or within 24 days of the filing of the displacement grievance, whichever is the shorter time period, unless good cause for late filing as described in subparagraph 7.5(4) "a"(1) is found.

(2) An appeal of a PROMISE JOBS discrimination complaint shall be made within the time frames provided in paragraph 7.5(4) "a" in relation to the action alleged to have involved discrimination.

f. Risk assessment standard. An appeal of a sex offender risk assessment shall be made in writing within 14 calendar days of issuance of the notice.

7.5(5) Informal settlements. The time limit for submitting an appeal is not extended while attempts at informal settlement are in progress.

7.5(6) Appeals of family investment program (FIP), refugee cash assistance (RCA), and PROMISE JOBS overpayments.

a. Subject to the time limits described in subrule 7.5(4), a person's right to appeal the existence, computation, and amount of a FIP, RCA, or PROMISE JOBS overpayment begins when the department sends the first notice informing the person of the overpayment. The notice shall be sent on:

1. Form 470-2616, Demand Letter for FIP/RCA Agency Error Overissuance;
2. Form 470-3490, Demand Letter for FIP/RCA Client Error Overissuance;
3. Form 470-3990, Demand Letter for PROMISE JOBS Agency Error Overissuance;
4. Form 470-3991, Demand Letter for PROMISE JOBS Client Error Overissuance; or
5. Form 470-3992, Demand Letter for PROMISE JOBS Provider Error Overissuance.

b. A hearing shall not be held if an appeal is filed in response to a second or subsequent notice as identified in paragraph "a."

c. Subject to the time limits described in subrule 7.5(4), a person's right to appeal the recovery of an overpayment through benefit reduction, as described at rule 441—46.25(239B), but not the existence, computation, or amount of an overpayment, begins when the person receives Notice of Decision or

Notice of Action, Form 470-0485, 470-0485(S), 470-0486, or 470-0486(S), informing the person that benefits will be reduced to recover a FIP or RCA overpayment.

7.5(7) Appeals of Medicaid, state supplementary assistance (SSA), and HAWK-I program overpayments.

a. Subject to the time limits described in subrule 7.5(4), a person's right to appeal the existence and amount of a medical assistance, state supplementary assistance, or healthy and well kids in Iowa (HAWK-I) program overpayment begins when the department sends the first notice informing the person of the overpayment. The notice shall be sent on:

- (1) Form 470-2891, Notice of Medical Assistance Overpayment; or
- (2) Form 470-3984, Notice of Healthy and Well Kids in Iowa (HAWK-I) Overpayment.

b. A hearing shall not be held if an appeal is filed in response to a second or subsequent notice as identified in paragraph "a."

7.5(8) Appeal rights under the family investment program limited benefit plan. A participant only has the right to appeal the establishment of the limited benefit plan once at the time the department issues the timely and adequate notice that establishes the limited benefit plan. However, when the reason for the appeal is based on an incorrect grant computation, an error in determining the eligible group, or another worker error, a hearing shall be granted when the appeal otherwise meets the criteria for hearing.

7.5(9) Appeals of child care assistance benefit overissuances or overpayments.

a. Subject to the time limits described in subrule 7.5(4), a person's right to appeal the existence, computation, and amount of a child care assistance benefit overissuance or overpayment begins when the department sends the first notice informing the person of the child care assistance overpayment. The notice shall be sent on Form 470-4530, Notice of Child Care Assistance Overpayment.

b. A hearing shall not be held if an appeal is filed in response to a second or subsequent notice about the same overpayment.

7.5(10) Appeals of food assistance overpayments.

a. Subject to the time limits described in subrule 7.5(4), a person's right to appeal the existence, computation, and amount of a food assistance overpayment begins when the department sends the first notice informing the person of the food assistance overpayment. The notice shall be sent on:

- (1) Form 470-0338, Demand Letter for Food Assistance Agency Error Overissuance;
- (2) Form 470-3486, Demand Letter for Food Assistance Intentional Program Violation Overissuance; or
- (3) Form 470-3487, Demand Letter for Food Assistance Inadvertent Household Error Overissuance.

b. Subject to the time limits described in subrule 7.5(4), a person's right to appeal the recovery of an overpayment through benefit reduction, but not the existence, computation, or amount of an overpayment, begins when the person receives Notice of Decision or Notice of Action, Form 470-0485, 470-0485(S), 470-0486, or 470-0486(S), informing the person that benefits will be reduced to recover a food assistance overpayment.

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441—7.6(17A) Informing persons of their rights.

7.6(1) Written and oral notification. The department shall advise each applicant and recipient of the right to appeal any adverse decision affecting the person's status.

a. Written notification of the following shall be given at the time of application and at the time of any agency action affecting the claim for assistance:

- (1) The right to request a hearing.
- (2) The procedure for requesting a hearing.
- (3) The right to be represented by others at the hearing unless otherwise specified by statute or federal regulation.
- (4) Provisions, if any, for payment of legal fees by the department.

b. Written notification shall be given on the application form and on all notices of decisions. Oral explanation shall also be given regarding the policy on appeals during the application process and at the time of any contemplated action by the agency when the need for an explanation is indicated.

c. Persons not familiar with English shall be provided a translation into the language understood by them in written form or orally. Appellants are entitled to have an interpreter present during appeal hearings. In all cases when a person is illiterate or semiliterate, the person shall be advised of each right to the satisfaction of the person's understanding.

d. Persons living with disabilities shall be provided assistance through the use of auxiliary aids and services at no cost to the individual in accordance with the Americans with Disabilities Act and Section 504 of the Rehabilitation Act.

7.6(2) *Authorized representation or responsible party.* Persons may be represented for purposes of this chapter by an authorized representative or an individual or organization recognized by the department as acting responsibly for an applicant or beneficiary pursuant to policy governing a particular program (hereinafter referred to as a "responsible party"), unless otherwise specified by statute or federal regulations.

a. The designation of an authorized representative must be in writing and include the signature of the person designating the authorized representative. Legal documentation of authority to act on behalf of a person, such as a court order establishing legal guardianship or a power of attorney, shall serve in place of a signed designation by the person.

b. An authorized representative or responsible party must agree to maintain, or be legally bound to maintain, the confidentiality of any information regarding an applicant or beneficiary provided by the department.

c. A provider or staff member or volunteer of an organization serving as an authorized representative or responsible party must sign an agreement that such provider, staff member or volunteer will adhere to the regulations in Part 431, Subpart F, of 42 CFR Chapter IV and in 45 CFR 155.260(f) (relating to confidentiality of information), § 447.10 of 42 CFR Chapter IV (relating to the prohibition against reassignment of provider claims as appropriate for a health facility or an organization acting on the facility's behalf), as well as other relevant state and federal laws concerning conflict of interest and confidentiality of information.

d. An authorized representative or responsible party may file an appeal on the appellant's behalf, receive copies of appeal correspondence, and act on behalf of the appellant in all other matters regarding the appeal.

e. The authorized representative or responsible party is responsible for fulfilling all responsibilities encompassed within the scope of the authorized representation to the same extent as the individual the authorized representative or responsible party represents.

f. The power to act as an authorized representative is valid until the appellant modifies the authorization or notifies the department that the representative is no longer authorized to act on the appellant's behalf, or the authorized representative informs the agency that the authorized representative is no longer acting in such capacity, or there is a change in the legal authority upon which the individual's or organization's authority was based. Such notice must be in writing and include the appellant's, authorized representative's or responsible party's signature as appropriate.

g. Designations of authorized representatives, legal documentation of authority to act on behalf of a person, and modifications or terminations of designations or legal authority may be submitted online via the department's Web site, by mail, by electronic mail, by facsimile transmission or in person.

h. For purposes of this rule, the department shall accept electronic, including telephonically recorded, signatures and handwritten signatures transmitted by facsimile or other electronic transmission.

i. Designations of authorized representatives, legal documentation of authority to act on behalf of a person, and modifications or terminations of designations or legal authority previously submitted to the department that comply with the requirements of this rule will continue to apply for purposes of appeals, consistent with their terms.

[ARC 8003B, IAB 7/29/09, effective 9/2/09; ARC 1261C, IAB 1/8/14, effective 3/1/14]

441—7.7(17A) Notice of intent to approve, deny, terminate, reduce, or suspend assistance or deny reinstatement of assistance.**7.7(1) Notification.**

a. Whenever the department proposes to cancel or reduce assistance or services or to revoke a license, certification, approval, registration, or accreditation, it shall give timely and adequate notice of the pending action, except:

(1) When a service is deleted from the state's comprehensive annual service plan in the social services block grant program at the onset of a new program year, or

(2) As provided in subrule 7.7(2).

b. For the purpose of this subrule, "assistance" includes food assistance, medical assistance, the family investment program, refugee cash assistance, child care assistance, emergency assistance, family or community self-sufficiency grant, PROMISE JOBS, state supplementary assistance, healthy and well kids in Iowa (HAWK-I) program, foster care, adoption, aftercare services, or other programs or services provided by the department.

c. The department shall give adequate notice of the approval or denial of assistance or services; the approval or denial of a license, certification, approval, registration, or accreditation; and pending action for a state or federal tax or debtor offset.

d. "Timely" means that the notice is sent at least ten calendar days before the date the action would become effective. The timely notice period shall begin on the day after the notice is sent.

e. "Adequate" means a written notice that includes:

(1) A statement of what action is being taken,

(2) The effective date of such action,

(3) A clear statement of the specific reasons supporting the intended action,

(4) The manual chapter number and subheading supporting the action and the corresponding rule reference,

(5) An explanation of the appellant's right to appeal, and

(6) The circumstances under which assistance is continued when an appeal is filed.

7.7(2) Dispensing with timely notice. Timely notice may be dispensed with, but adequate notice shall be sent no later than the date benefits would have been issued when:

a. There is factual information confirming the death of a recipient or of the family investment program payee when there is no relative available to serve as a new payee.

b. The recipient provides a clear written, signed statement that the recipient no longer wishes assistance, or gives information which requires termination or reduction of assistance, and the recipient has indicated, in writing, that the recipient understands this must be the consequence of supplying the information.

c. The recipient has been admitted or committed to an institution that does not qualify for payment under an assistance program.

d. The recipient has been placed in skilled nursing care, intermediate care, or long-term hospitalization.

e. The recipient's whereabouts are unknown and mail directed to the recipient has been returned by the post office indicating no known forwarding address. When the recipient's whereabouts become known during the payment period covered by the returned warrant, the warrant shall be made available to the recipient.

f. The agency establishes that the recipient has been accepted for assistance in another state.

g. Cash assistance or food assistance is changed because a child is removed from the home as a result of a judicial determination or is voluntarily placed in foster care.

h. A change in the level of medical care is prescribed by the recipient's physician.

i. A special allowance or service granted for a specific period is terminated and the recipient has been informed in writing at the time of initiation that the allowance or service shall terminate at the end of the specified period.

j. The notice involves an adverse determination made with regard to the preadmission screening requirements.

k. The department terminates or reduces benefits or makes changes based on a completed Form 470-2881, 470-2881(S), 470-2881(M), or 470-4083(MS), Review/Recertification Eligibility Document, as described at 441—paragraph 40.27(1)“*b*”or rule 441—75.52(249A).

l. The agency terminates benefits for failure to return a completed report form, as described in paragraph “*k*.”

m. The agency approves or denies an application for assistance.

n. The agency implements a mass change based on law or rule changes that affect a group of recipients.

7.7(3) Action due to probable fraud. When the agency obtains facts indicating that assistance should be canceled, suspended, or reduced because of the probable fraud of the recipient, and, where possible, the facts have been verified through collateral sources, notice of the action shall be timely when sent at least five calendar days before the action would become effective. The notice shall be sent by certified mail, return receipt requested.

7.7(4) Conference during the timely notice period. Rescinded IAB 7/10/13, effective 9/1/13.

7.7(5) Notification not required. Notification is not required in the following instances:

a. When services in the social service block grant preexpenditure report are changed from one plan year to the next, or when the plan is amended because funds are no longer available.

b. When service has been time-limited in the social service block grant preexpenditure report, and as a result the service is no longer available.

c. When the placement of a person(s) in foster care is changed.

d. When payment has been in accordance with the Medicaid payment schedule for the service billed because there is no adverse action.

e. When services of the community self-sufficiency grant project are available to all PROMISE JOBS participants as specified in 441—subrule 47.46(1).

7.7(6) Reinstatement.

a. Whenever the department determines that a previously canceled case must remain canceled for a reason other than that covered by the original notice, timely and adequate notice shall be sent except as specified in subrule 7.7(2).

b. Whenever the department determines that a previously canceled case is eligible for reinstatement at a lower level of benefits, for a reason other than that covered by the original notice, timely and adequate notice shall be sent except as specified in subrule 7.7(2).

c. Food assistance cases are eligible for reinstatement only in circumstances found in rule 441—65.44(234). FIP cases are eligible for reinstatement only in circumstances found in 441—subrule 40.22(5).

[ARC 8003B, IAB 7/29/09, effective 9/2/09; ARC 0819C, IAB 7/10/13, effective 9/1/13; ARC 1261C, IAB 1/8/14, effective 3/1/14]

441—7.8(17A) Opportunity for hearing.

7.8(1) Initiating an appeal. To initiate an appeal, a person, the person’s authorized representative or an individual or organization recognized by the department as acting responsibly for the person pursuant to policy governing a particular program must state in writing that the person disagrees with a decision, action, or failure to act on the person’s case.

a. All appeals shall be made in writing, except for food assistance, Medicaid and healthy and well kids in Iowa appeals, which may be made by telephone or in person.

b. A written request may be submitted via the department’s Web site or may be delivered by mail, electronic mail, facsimile transmission or personal delivery to the appeals section, to the local office, or to the department office that took the adverse action.

c. A request by telephone or in person may be made to the appeals section or to the department office that took the adverse action.

7.8(2) Filing the appeal. The appellant shall be encouraged, but not required, to make written appeal on Form 470-0487 or 470-0487(S), Appeal and Request for Hearing, and the worker shall provide any instructions or assistance required in completing the form. When the appellant is unwilling to complete or sign this form, nothing in this rule shall be construed to preclude the right to perfect the appeal, as

long as the appeal is in writing (except for food assistance, Medicaid and healthy and well kids in Iowa appeals) and has been communicated to the department by the appellant or appellant's representative.

A written appeal submitted by mail is filed on the date postmarked on the envelope sent to the department, or, when the postmarked envelope is not available, on the date the appeal is stamped received by the agency. When an appeal is submitted through an electronic delivery method, such as electronic mail, submission of an online form, or facsimile, the appeal is filed on the date it is submitted. The electronic delivery method shall record the date and time the appeal request was submitted. If there is no date recorded by the electronic delivery method, the date of filing is the date the appeal is stamped received by the agency. Receipt date of all appeals shall be documented by the office where the appeal is received.

7.8(3) *Informal conference.* When requested by the appellant, an informal conference with a representative of the department shall be held as soon as possible after the appeal has been filed. An appellant's representative shall be allowed to attend and participate in the informal conference, unless precluded by federal rule or state statute.

An informal conference need not be requested for the appellant to examine the contents of the case record, including any electronic case record, as provided in subrule 7.13(1) and 441—Chapter 9.

7.8(4) *Prehearing conference.* When requested by the appellant or department, a prehearing conference may be held with the appellant, a representative of the department and a presiding officer as soon as possible after the appeal has been filed. An appellant's representative shall be allowed to attend and participate in the prehearing conference, unless precluded by federal rule or state statute.

7.8(5) *Interference.* Neither an informal conference nor a prehearing conference shall be used to discourage appellants from proceeding with their appeals. The right of appeal shall not be limited or interfered with in any way, even though the person's complaint may be without basis in fact, or because of the person's own misinterpretation of law, agency policy, or methods of implementing policy.

7.8(6) *Right of the department to deny or dismiss an appeal.* The department or the department of inspections and appeals has the right to deny or dismiss the appeal when:

- a. It has been withdrawn by the appellant pursuant to subrule 7.8(8).
- b. The sole issue is one of state or federal law requiring automatic grant adjustments for classes of recipients.
- c. It has been abandoned.
- d. The agency, by written notice, withdraws the action appealed and restores the appellant's status that existed before the action appealed was taken.
- e. The agency implements action and issues a notice of decision or notice of action to correct an error made by the agency which resulted in the appeal.

Abandonment may be deemed to have occurred when the appellant or the appellant's authorized representative fails, without good cause, to appear at the prehearing or hearing.

7.8(7) *Denial of due process.* Facts of harassing, threats of prosecution, denial of pertinent information needed by the appellant in preparing the appeal, as a result of the appellant's communicated desire to proceed with the appeal shall be taken into consideration by the administrative law judge in reaching a proposed decision.

7.8(8) *Withdrawal.* When the appellant desires to voluntarily withdraw an appeal, the worker, the presiding officer, or the appeals section shall accept a request from the appellant to withdraw the appeal by telephone, in writing or in person. A written request may be submitted in person, by mail or through an electronic delivery method, such as electronic mail, submission of an online form, or facsimile. The appellant may use Form 470-0492 or 470-0492(S), Request for Withdrawal of Appeal, for this purpose. For child abuse and dependent adult abuse appeals, the request to withdraw an appeal must be made in writing and signed by the appellant or the appellant's legal counsel.

7.8(9) *Department's responsibilities.* Unless the appeal is voluntarily withdrawn, the department worker or agent responsible for representing the department at the hearing shall:

- a. Within one working day of receipt, complete the worker information section of Form 470-0487 or 470-0487(S), Appeal and Request for Hearing, and forward that form, the written appeal, the

postmarked envelope, if there is one, and a copy of the notification of the proposed adverse action to the appeals section.

b. Forward a summary and supporting documentation of the worker's factual basis for the proposed action to the appeals section within ten days of the receipt of the appeal.

c. Provide the appellant and the appellant's representative copies of all materials sent to the appeals section or the presiding officer to be considered in reaching a decision on the appeal at the same time as the materials are sent to the appeals section or the presiding officer.

[ARC 8003B, IAB 7/29/09, effective 9/2/09; ARC 0487C, IAB 12/12/12, effective 2/1/13; ARC 0819C, IAB 7/10/13, effective 9/1/13; ARC 1261C, IAB 1/8/14, effective 3/1/14]

441—7.9(17A) Continuation of assistance pending a final decision on appeal.

7.9(1) *When assistance continues.*

a. Assistance, subject to paragraph 7.9(1)“b,” shall not be suspended, reduced, restricted, or canceled, nor shall a license, registration, certification, approval, or accreditation be revoked or other proposed adverse action be taken pending a final decision on an appeal when:

- (1) An appeal is filed before the effective date of the intended action; or
- (2) The appellant requests a hearing within ten days from receipt of a notice suspending, reducing, restricting, or canceling benefits or services.

The date on which the notice is received is considered to be five days after the date on the notice, unless the beneficiary shows that the beneficiary did not receive the notice within the five-day period.

b. If it is determined at a hearing that the issue involves only federal or state law or policy, assistance will be immediately discontinued.

7.9(2) *When assistance does not continue.* Assistance shall be suspended, reduced, restricted, or canceled; a license, registration, certification, approval, or accreditation shall be revoked; and other proposed action shall be taken pending a final decision on appeal when:

a. An appeal is not filed before the effective date of the intended action or within ten days from the date notice is received. The date on which notice is received is considered to be five days after the date on the notice, unless the beneficiary shows that the beneficiary did not receive the notice within the five-day period.

b. Benefits or services were time-limited through a certification period or prior authorization for which notice was given when established or for which adequate notice was provided.

c. The appellant directs the worker in writing to proceed with the intended action.

d. Adverse action was taken because the appellant failed to return a complete review form.

7.9(3) *Recovery of excess assistance paid pending a final decision on appeal.* Continued assistance is subject to recovery by the department if its action is affirmed, except as specified at subrule 7.9(5).

When the department action is sustained, excess assistance paid pending a hearing decision shall be recovered to the date of the decision. This recovery is not an appealable issue. However, appeals may be heard on the computation of excess assistance paid pending a hearing decision.

7.9(4) *Recovery of excess assistance paid when the appellant's benefits are changed prior to a final decision.* Recovery of excess assistance paid will be made to the date of change which affects the improper payment. The recovery shall be made when the appellant's benefits are changed due to one of the following reasons:

a. A determination is made at the hearing that the sole issue is one of state or federal law or policy or change in state or federal law or policy and not one of incorrect grant computation, and the grant is adjusted.

b. A change affecting the appellant's grant occurs while the hearing decision is pending and the appellant fails to request a hearing after notice of the change.

7.9(5) *Recovery of assistance when a new limited benefit plan is established.* Assistance issued pending the final decision of the appeal is not subject to recovery when a new limited benefit plan period is established. A new limited benefit plan period shall be established when the department is affirmed in a timely appeal of the establishment of the limited benefit plan. All of the following conditions shall exist:

- a.* The appeal is filed either:
 - (1) Before the effective date of the intended action on the notice of decision or notice of action establishing the beginning date of the LBP, or
 - (2) Within ten days from the date on which a notice establishing the beginning date of the LBP is received. The date on which notice is received is considered to be five days after the date on the notice, unless the beneficiary shows that the beneficiary did not receive the notice within the five-day period.
- b.* Assistance is continued pending the final decision of the appeal.
- c.* The department's action is affirmed.

7.9(6) *Recovery of assistance when a new ineligibility period is established for the use of an electronic access card at a prohibited location.* Assistance issued pending the final decision of the appeal is not subject to recovery when a new ineligibility period is established for the use of an electronic access card at a prohibited location. A new ineligibility period pursuant to 441—subrule 41.25(11) shall be established when the department is affirmed in an appeal of the establishment of an ineligibility period for the use of an electronic access card at a prohibited location. All of the following conditions shall exist:

- a.* The appeal is filed either:
 - (1) Before the effective date of the intended action on the notice of decision or notice of action establishing the beginning date of the ineligibility period, or
 - (2) Within ten days from the date on which a notice establishing the beginning date of the ineligibility period is received. The date on which notice is received is considered to be five days after the date on the notice, unless the beneficiary shows that the beneficiary did not receive the notice within the five-day period.
- b.* Assistance is continued pending the final decision of the appeal.
- c.* The department's action is affirmed.

[ARC 8003B, IAB 7/29/09, effective 9/2/09; ARC 1261C, IAB 1/8/14, effective 3/1/14; ARC 1478C, IAB 6/11/14, effective 8/1/14; ARC 1694C, IAB 10/29/14, effective 1/1/15]

441—7.10(17A) Procedural considerations.

7.10(1) *Registration.* Upon receipt of the notice of appeal, the department shall register the appeal.

7.10(2) *Acknowledgment.*

- a.* Upon receipt of the notice of appeal, the department shall send an acknowledgment of receipt of the appeal to the appellant, representative, or both. A copy of the acknowledgment of receipt of appeal will be sent to the appropriate departmental office.
- b.* For an appeal regarding child abuse, all subjects other than the person alleged responsible (appellant) will be notified of the opportunity to file a motion to intervene as provided in Iowa Code section 235A.19.

- c.* The department shall advise the person of any legal services which may be available and that the person may be represented by counsel at the person's own expense.

7.10(3) *Granting a hearing.* The department shall determine whether an appellant may be granted a hearing and the issues to be discussed at that hearing in accordance with the applicable rules, state statutes, or federal regulations.

- a.* The appeals of those appellants who are granted a hearing shall be certified to the department of inspections and appeals for the hearing to be conducted. The department shall indicate at the time of certification the issues to be discussed at that hearing.
- b.* The appeals of those appellants who are denied a hearing shall not be closed until issuance of a letter to the appellant and the appellant's representative, advising of the denial of hearing and the basis upon which that denial is made. Any appellant that disagrees with a denial of hearing may present additional information relative to the reason for denial and request reconsideration by the department or a hearing over the denial.

7.10(4) *Hearing scheduled.* For those records certified for hearing, the department of inspections and appeals shall establish the date, time, method and place of the hearing, with due regard for the

convenience of the appellant as set forth in department of inspections and appeals rules 481—Chapter 10 unless otherwise designated by federal or state statute or regulation.

a. In cases involving individual appellants, the hearing shall be held by teleconference call or in the appropriate department office.

b. In cases of appeals by vendors or agencies, the hearing shall be scheduled by teleconference call or at the most appropriate department office.

c. In cases involving the determination of the community spouse resource allowance, the hearing shall be held within 30 days of the date of the appeal request.

d. In cases involving an appeal of a sex offender risk assessment, the hearing shall be held within 30 days of the date of the appeal request.

e. Emergency assistance appeals shall be expedited.

7.10(5) *Method of hearing.* The department of inspections and appeals shall determine whether the appeal hearing is to be conducted in person, by videoconference or by teleconference call. The parties to the appeal may participate from multiple sites for videoconference or teleconference hearings. Any appellant is entitled to an in-person hearing if the appellant requests one. All parties shall be granted the same rights during a teleconference hearing as specified in 441—7.13(17A). The appellant may request to have a presiding officer render a decision for attribution appeals through an administrative hearing.

7.10(6) *Reschedule requests.* Requests by the appellant or the department to set another date, time, method or place of hearing shall be made to the department of inspections and appeals directly except as otherwise noted. The granting of the requests will be at the discretion of the department of inspections and appeals.

a. The appellant may request that the teleconference hearing be rescheduled as an in-person hearing. All requests made to the department or to the department of inspections and appeals for a teleconference hearing to be rescheduled as an in-person hearing shall be granted. Any appellant request for an in-person hearing made to the department shall be communicated to the department of inspections and appeals immediately.

b. All other requests concerning the scheduling of a hearing shall be made to the department of inspections and appeals directly.

7.10(7) *Notification.* For those appeals certified for hearing, the department of inspections and appeals shall send a notice to the appellant at least ten calendar days in advance of the hearing date.

a. The notice, as prescribed in Iowa Code section 17A.12(2), shall set forth:

(1) The date, time, method and place of the hearing;

(2) That evidence may be presented orally or documented to establish pertinent facts; and

(3) That the appellant may question or refute any testimony, may bring witnesses of the appellant's choice and may be represented by others, including an attorney, subject to federal law and state statute. The department will not pay for the cost of legal representation.

b. A copy of this notice shall be forwarded to the department employee who took the action and to other persons when circumstances peculiar to the case indicate that the notification may be desirable.

c. Notices of hearing regarding an intentional program violation shall be served upon the appellant both by certified mail, return receipt requested, and by first-class mail, postage prepaid, addressed to the appellant at the last-known address. All other notices of hearing shall be mailed by first-class mail, postage prepaid, addressed to the appellant at the appellant's last-known address.

[ARC 8003B, IAB 7/29/09, effective 9/2/09; ARC 0487C, IAB 12/12/12, effective 2/1/13; ARC 1261C, IAB 1/8/14, effective 3/1/14]

441—7.11(17A) Information and referral for legal services. The local office shall advise persons appealing any agency decision of legal services in the community that are willing to assist them.

441—7.12(17A) Subpoenas. The department shall have all subpoena power conferred upon it by statute. Departmental subpoenas shall be issued to a party on request or will be served by the department when requested at least one week in advance of the hearing date.

441—7.13(17A) Rights of appellants during hearings.

7.13(1) Examination of the evidence. The department shall provide the appellant, or representative, opportunity prior to, as well as during, the hearing, to examine all materials permitted under rule 441—9.1(17A,22) or to be offered as evidence. Off the record, or confidential information which the appellant or representative does not have the opportunity to examine shall not be included in the record of the proceedings or considered in reaching a decision.

7.13(2) Conduct of hearing.

a. The hearing shall be conducted by an administrative law judge designated by the department of inspections and appeals. It shall be an informal rather than a formal judicial procedure and shall be designed to serve the best interest of the appellant. The appellant shall have the right to introduce any evidence on points at issue believed necessary, to challenge and cross-examine any statement made by others, and to present evidence in rebuttal. A verbatim record shall be kept of the evidence presented.

b. For an appeal hearing regarding child abuse, the administrative law judge, upon request of any party to the hearing, may stay the hearing until the conclusion of the adjudicatory phase of a pending juvenile or district court case relating to the data or findings as provided in Iowa Code section 235A.19.

7.13(3) Opportunity for response. Opportunity shall be afforded all parties to respond and present evidence and arguments on all issues involved and to be represented by counsel at their own expense.

7.13(4) Default. If a party to the appeal fails to appear or participate in a contested case proceeding after proper service of notice, the presiding officer may, if no adjournment is granted, enter a default decision or proceed with the hearing pursuant to subrules 7.13(1), 7.13(2) and 7.13(3) and render a proposed decision on the merits in the absence of the defaulting party.

a. Where appropriate and not contrary to law, any party may move for a default decision against a party who has failed to file a required pleading or has failed to appear after proper service for a hearing. A proposed decision on the merits may be issued in the absence of a defaulting party.

b. A default decision or a proposed decision rendered on the merits in the absence of the defaulting party may award any relief against the defaulting party consistent with the relief requested before the default, but the relief awarded against the defaulting party may not exceed the requested relief before the default.

c. Proceedings after a default decision are specified in subrule 7.13(5).

d. Proceedings after a hearing and a proposed decision on the merits in the absence of a defaulting party are specified in subrule 7.13(6).

7.13(5) Proceedings after default decision.

a. Default decisions or decisions rendered on the merits after a party has failed to appear or participate in a contested case proceeding become final agency action unless a motion to vacate the decision is filed within the time allowed for an appeal of a proposed decision by subrule 7.16(5).

b. A motion to vacate must state all facts relied upon by the moving party which establish that good cause existed for the party's failure to appear or participate at the contested case proceeding and must be filed with the Department of Human Services, Appeals Section, Fifth Floor, 1305 East Walnut Street, Des Moines, Iowa 50319-0114. Each fact so stated must be substantiated by at least one sworn affidavit of a person with personal knowledge of each such fact. Each affidavit must be attached to the motion. In lieu of an affidavit, the moving party may submit business records or other acceptable documentation from a disinterested third party that substantiates the claim of good cause.

(1) The appeals section shall be responsible for serving all parties with the motion to vacate. All parties to the appeal shall have ten days from service by the department to respond to the motion to vacate. All parties to the appeal shall be allowed to conduct discovery as to the issue of good cause and shall be allowed to present evidence on the issue before a decision on the motion, if a request to do so is included in that party's response. If the department responds to any party's motion to vacate, all parties shall be allowed another ten days to respond to the department.

(2) The appeals section shall certify the motion to vacate to the department of inspections and appeals for the presiding officer to review the motion, hold any additional proceedings, as appropriate, and determine if good cause exists to set aside the default.

c. Properly substantiated and timely filed motions to vacate shall be granted only for good cause shown. The burden of proof as to good cause is on the moving party.

d. “Good cause” for purposes of this rule is defined as an emergency circumstance that is beyond the control of the party and that prevents the party from being able to participate in the hearing.

(1) Examples of good cause include, but are not limited to:

1. Sudden, severe illness or accident involving the party or the party’s immediate family (spouse, partner, children, parents, sibling).

2. Death or serious illness in the party’s immediate family.

3. Other circumstances evidencing an emergency situation which was beyond the party’s control and was not reasonably foreseeable.

(2) Examples of circumstances that do not constitute good cause include, but are not limited to:

1. A lost or misplaced notice of hearing.

2. Confusion as to the date and time for the hearing.

3. Failure to follow the directions on the notice of hearing.

4. Oversleeping.

5. Other acts demonstrating a lack of due care by the party.

e. Upon determining whether good cause exists, the presiding officer shall issue a proposed decision on the motion to vacate, which shall be subject to review by the director pursuant to rule 441—7.16(17A).

f. Upon a final decision granting a motion to vacate, the contested case hearing shall proceed accordingly, after proper service of notice to all parties. The situation shall be treated as the filing of a new appeal for purposes of calculating time limits, with the filing date being the date the decision granting the motion to vacate became final.

g. Upon a final decision denying a motion to vacate, the default decision becomes final agency action.

7.13(6) *Proceedings after hearing and proposed decision on the merits in the absence of a defaulting party.*

a. Proposed decisions on the merits after a party has failed to appear or participate in a contested case become final agency action unless:

(1) A motion to vacate the proposed decision is filed by the defaulting party based on good cause for the failure to appear or participate, within the time allowed for an appeal of a proposed decision by subrule 7.16(5); or

(2) Any party requests review on the merits by the director pursuant to rule 441—7.16(17A).

b. If a motion to vacate and a request for review on the merits are both made in a timely manner after a proposed decision on the merits in the absence of a defaulting party, the review by the director on the merits of the appeal shall be stayed pending the outcome of the motion to vacate.

c. A motion to vacate must state all facts relied upon by the moving party which establish that good cause existed for the party’s failure to appear or participate at the contested case proceeding and must be filed with the Department of Human Services, Appeals Section, Fifth Floor, 1305 East Walnut Street, Des Moines, Iowa 50319-0114.

(1) The appeals section shall be responsible for serving all parties with the motion to vacate. All parties to the appeal shall have ten days from service by the department to respond to the motion to vacate. All parties to the appeal shall be allowed to conduct discovery as to the issue of good cause and shall be allowed to present evidence on the issue before a decision on the motion, if a request to do so is included in that party’s response. If the department responds to any party’s motion to vacate, all parties shall be allowed another ten days to respond to the department.

(2) The appeals section shall certify the motion to vacate to the department of inspections and appeals for the presiding officer to review the motion, hold any additional proceedings, as appropriate, and determine if good cause exists to set aside the default.

d. Properly substantiated and timely filed motions to vacate shall be granted only for good cause shown. The burden of proof as to good cause is on the moving party.

e. “Good cause” for purposes of this rule is defined as an emergency circumstance that is beyond the control of the party and that prevents the party from being able to participate in the hearing.

(1) Examples of good cause include, but are not limited to:

1. Sudden, severe illness or accident involving the party or the party’s immediate family (spouse, partner, children, parents, sibling).
2. Death or serious illness in the party’s immediate family.
3. Other circumstances evidencing an emergency situation which was beyond the party’s control and was not reasonably foreseeable.

(2) Examples of circumstances that do not constitute good cause include, but are not limited to:

1. A lost or misplaced notice of hearing.
2. Confusion as to the date and time for the hearing.
3. Failure to follow the directions on the notice of hearing.
4. Oversleeping.
5. Other acts demonstrating a lack of due care by the party.

f. Upon determining whether good cause exists, the presiding officer shall issue a proposed decision on the motion to vacate, which shall be subject to review by the director pursuant to rule 441—7.16(17A).

g. Upon a final decision granting a motion to vacate, a new contested case hearing shall be held after proper service of notice to all parties. The situation shall be treated as the filing of a new appeal for purposes of calculating time limits, with the filing date being the date the decision granting the motion to vacate became final.

h. Upon a final decision denying a motion to vacate, the proposed decision on the merits in the absence of a defaulting party becomes final unless there is request for review on the merits by the director made pursuant to paragraph 7.13(6) “a” or “j.”

i. Any review on the merits by the director requested pursuant to paragraph 7.13(6) “a” and stayed pursuant to paragraph 7.13(6) “b” pending a decision on a motion to vacate shall be conducted upon a final decision denying the motion to vacate.

j. Upon a final decision denying a motion to vacate a proposed decision issued in the absence of a defaulting party, any party to the contested case proceeding may request a review on the merits by the director pursuant to rule 441—7.16(17A), treating the date that the denial of the motion to vacate became final as the date of the proposed decision.

[ARC 8003B, IAB 7/29/09, effective 9/2/09; ARC 0304C, IAB 9/5/12, effective 11/1/12; ARC 0487C, IAB 12/12/12, effective 2/1/13]

441—7.14(17A) Limitation of persons attending.

7.14(1) The hearing shall be limited in attendance to the following persons, unless otherwise specified by statute or federal regulations: appellant, appellant’s representative, agency employees, agency’s legal representatives, other persons present for the purpose of offering testimony pertinent to the issues in controversy, and others upon mutual agreement of the parties. The administrative law judge may sequester witnesses during the hearing. Nothing in this rule shall be construed to allow members of the press, news media, or any other citizens’ group to attend the hearing without the written consent of the appellant.

7.14(2) For an appeal hearing regarding child abuse:

a. Subjects who file a motion to intervene, as provided in Iowa Code section 235A.19, will have the opportunity to appear at the prehearing conference. Any motion to intervene shall be considered by the administrative law judge at the prehearing conference.

b. The department shall not be considered to be a party who can adequately represent the interests of any other subject.

c. Subjects allowed to intervene as specified in subrule 7.5(4) will be considered parties to the hearing and will be allowed to attend the proceedings as provided in Iowa Code section 235A.19.

[ARC 0487C, IAB 12/12/12, effective 2/1/13]

441—7.15(17A) Medical examination. When the hearing involves medical issues, a medical assessment or examination by a person or physician other than the one involved in the decision under

question shall be obtained and the report made a part of the hearing record when the administrative law judge or appellant considers it necessary. Any medical examination required shall be performed by a physician satisfactory to the appellant and the department at agency expense.

Forms 470-0502, Authorization for Examination and Claim for Payment, and 470-0447, Report on Incapacity, shall be utilized in obtaining medical information to be used in the appeal and to authorize payment for the examination.

441—7.16(17A) The appeal decision.

7.16(1) *Record.* The record in a contested case shall include, in addition to those materials specified in Iowa Code section 17A.12(6):

- a. The notice of appeal.
- b. All evidence received or considered and all other submissions, including the verbatim record of the hearing.

7.16(2) *Findings of fact.* Any party may submit proposed findings of fact. The presiding officer will rule on the proposed findings of fact. Findings of fact shall be based solely on the evidence in the record and on matters officially noticed in the record. The findings of fact and conclusions of law in the proposed or final decision shall be limited to contested issues of fact, policy, or law.

7.16(3) *Proposed decision.* Following the reception of evidence, the presiding officer shall issue a proposed decision, consisting of the issues of the appeal, the decision, the findings of fact and the conclusions of law. Each item shall be separately stated under individual headings. The proposed decision shall be sent by first-class mail, postage prepaid, addressed to the appellant at the appellant's last-known address.

7.16(4) *Appeal of the proposed decision.* After issuing a proposed decision, the administrative law judge shall submit it to the department with copies to the appeals advisory committee.

a. The appellant, appellant's representative, a subject allowed to intervene as specified in subrule 7.5(4), the representative of a subject allowed to intervene as specified in subrule 7.5(4), or the department may appeal for the director's review of the proposed decision.

b. When the appellant, a subject allowed to intervene as specified in subrule 7.5(4), or the department has not appealed the proposed decision or when an appeal for the director's review of the proposed decision is not granted, the proposed decision shall become the final decision.

c. The director's review on appeal of the proposed decision shall be on the basis of the record as defined in subrule 7.16(1), except that the director need not listen to the verbatim record of the hearing in a review or appeal. The review or appeal shall be limited to issues raised prior to that time and specified by the party requesting the appeal or review. The director may designate another to act on the director's behalf in making final decisions.

7.16(5) *Time limit for appeal of a proposed decision.* Appeal for the director's review of the proposed decision must be made in writing to the director. The written request must be mailed or submitted in person or through an electronic delivery method, such as electronic mail, submission of an online form, or facsimile. The request must be postmarked or received within ten calendar days of the date on which the proposed decision was sent. The day after the proposed decision is sent is the first day of the time period within which a request for review must be filed. When the time limit for filing falls on a holiday or a weekend, the time will be extended to the next workday.

7.16(6) *Appeal of the proposed decision by the department.* The appeals advisory committee acts as an initial screening device for the director and may recommend that the director review a proposed decision. That recommendation is not binding upon the director, and the director may decide to review a proposed decision without that committee's recommendation.

A request by the department for director's review of the proposed decision must be made in writing. The written request must be submitted to the appeals section in person or submitted through an electronic delivery method, such as electronic mail or facsimile, within ten calendar days of the date on which the proposed decision was sent. The day after the proposed decision is sent is the first day of the time period within which a request for director's review must be filed. When the time limit for filing falls on a holiday or a weekend, the time will be extended to the next workday.

When the director grants a review of a proposed decision on the department's request, the appeals section shall notify all other parties to the appeal of the review and send a copy of the request to all other parties. All other parties shall be provided ten calendar days from the date of notification to submit further written arguments or objections for consideration upon review.

Written arguments or objections must be mailed or submitted in person to the appeals section or submitted through an electronic delivery method, such as electronic mail, submission of an online form, or facsimile.

The day after the notification is sent is the first day of the time period within which a response to the department's request for review must be filed. When the time limit for responding falls on a holiday or a weekend, the time will be extended to the next workday.

7.16(7) *Appeal of the proposed decision by the appellant.* When the director grants a review of a proposed decision all other parties shall be so notified.

7.16(8) *Opportunity for oral presentation of appeal of the proposed decision.* In cases where there is an appeal of a proposed decision each party shall be afforded an opportunity to present oral arguments with the consent of the director. Any party wishing oral argument shall specifically request it. When granted, all parties shall be notified of the time and place.

7.16(9) *Time limits.*

a. A final decision on the appeal shall be issued within the following time frames:

(1) Appeals for all programs, except food assistance and vendors, shall be rendered within 90 days from the date of the appeal.

(2) Food assistance-only decisions shall be rendered within 60 days.

(3) PROMISE JOBS displacement grievance decisions shall be rendered within 90 days from the date the displacement grievance was filed with the PROMISE JOBS contractee.

b. Failure to reach a decision within the time frames set forth in paragraph 7.16(9) "a" shall not affect the merits of the appellant's appeal.

c. Time frames may be extended based on continuances or additional time frames as approved by the presiding officer. Should the appellant request a delay in the hearing in order to prepare the case or for other essential reasons, reasonable time, not to exceed 30 days except with the approval of the administrative law judge, shall be granted and the extra time shall be added to the maximum for final administrative action.

d. For an appeal regarding child abuse, if the proposed decision is not appealed within 10 days from the date of the proposed decision, the proposed decision shall be the final agency action. If a party files an appeal within 10 days from the date of the proposed decision, the director has 45 days from the date of the proposed decision to issue a ruling. If the director does not rule within that 45-day period, the proposed decision becomes the final decision as provided in Iowa Code section 235A.19.

e. The department shall take prompt, definite and final administrative action to carry out the decision rendered within seven calendar days of receipt of a copy of the final decision. When the final decision is favorable to the appellant, or when the department decides in favor of the appellant before the hearing, the department shall make any additional corrective payments due, retroactive to the date of the incorrect action.

7.16(10) *Final decision.* The department shall mail the final decision to the appellant at the appellant's last-known address by first-class mail, postage prepaid.

[ARC 8003B, IAB 7/29/09, effective 9/2/09; ARC 0487C, IAB 12/12/12, effective 2/1/13; ARC 1261C, IAB 1/8/14, effective 3/1/14; ARC 1611C, IAB 9/3/14, effective 11/1/14]

441—7.17(17A) Exhausting administrative remedies. To have exhausted all adequate administrative remedies, a party need not request a rehearing under Iowa Code section 17A.16(2) where the party accepts the findings of fact as prepared by the administrative law judge, but wishes to challenge the conclusions of law, or departmental policy.

441—7.18(17A) Ex parte communication.

7.18(1) *Prohibited communication.* There shall be no written, oral, or other type of communication between the presiding officer and any party or representative of any party or any other person with a

direct or indirect interest in the case while an appeal is pending, without all parties being notified of an opportunity to participate, unless specifically authorized by statute or rule.

a. This provision does not prevent the presiding officer from communicating with members of the agency or seeking the advice or help of persons other than those defined in paragraph “c.”

b. Persons described in paragraph “c” shall not directly or indirectly communicate to the presiding officer any ex parte communications they have received of a type that the presiding officer would be prohibited from receiving or that furnish, augment, diminish, or modify the evidence in the record.

c. For purposes of this rule:

(1) People with a direct or indirect interest in a case include any member of the appeals advisory committee and any person engaged in personally investigating, prosecuting, or advocating in either the case under appeal or a pending factually related case involving the same parties.

(2) The term “personally investigating” means taking affirmative steps to interview witnesses directly or to obtain documents or other information directly. The term does not include general direction and supervision of assigned investigators, unsolicited receipt of information which is relayed to assigned investigators, review of another person’s investigative work product in the course of determining whether there is probable cause to initiate a proceeding, or exposure to factual information while performing other agency functions, including fact gathering for purposes other than investigation of the matter which culminates in a contested case.

7.18(2) *Commencement of prohibition.* Prohibitions on ex parte communications commence with the issuance of the notice of hearing in a contested case and continue for as long as the case is pending.

7.18(3) *When communication is ex parte.* Rescinded IAB 4/30/03, effective 7/1/03.

7.18(4) *Avoidance of ex parte communication.* To avoid prohibited ex parte communications, notice must be given in a manner reasonably calculated to give all parties a fair opportunity to participate. Written communications shall be provided to all parties to the appeal.

7.18(5) *Communications not prohibited.* Communications with the presiding officer involving uncontested scheduling or procedural matters do not require notice or opportunity for parties to participate. Parties should notify other parties prior to initiating such contact with the presiding officer when feasible, and shall notify other parties when seeking to continue hearings or other deadlines.

7.18(6) *Disclosure of prohibited communications.* A presiding officer who receives a prohibited ex parte communication during the pendency of a contested case must initially determine if the effect of the communication is so prejudicial that the presiding officer should be disqualified from the case. If the presiding officer determines that disqualification is warranted, a copy of any prohibited written communication, all written responses to the communication, a written summary stating the substance of any prohibited oral or other communication not available in written form for disclosure, all responses made, and the identity of each person from whom the presiding officer received a prohibited ex parte communication shall be disclosed. If the presiding officer determines that disqualification is not warranted, such documents shall be submitted for inclusion in the record and served on all parties. Any party desiring to rebut the prohibited communication must be allowed the opportunity to do so upon written request filed within ten days after notice of communication.

7.18(7) *Disclosure of prior receipt of information through ex parte communication.* Promptly after being assigned to serve as presiding officer at any stage in a contested case proceeding, a presiding officer shall disclose to all parties material factual information received through ex parte communication prior to such assignment unless the factual information has already been or shortly will be disclosed pursuant to Iowa Code section 17A.13(2) or through discovery. Factual information contained in an investigative report or similar document need not be separately disclosed by the presiding officer as long as such documents have been or will shortly be provided to the parties.

7.18(8) *Imposition of sanctions.* The presiding officer may render a proposed or final decision imposing appropriate sanctions for violations of this rule, including default, a decision against the offending party, censure, or suspension or revocation of the privilege to practice before the agency. Violation of ex parte communication prohibitions by department personnel shall be reported to the department for possible sanctions, including censure, suspension, dismissal, or other disciplinary action.

441—7.19(17A) Accessibility of hearing decisions. Summary reports of all hearing decisions shall be made available to local offices and the public. The information shall be presented in a manner consistent with requirements for safeguarding personal information concerning applicants and recipients.

441—7.20(17A) Right of judicial review and stays of agency action.

7.20(1) *Right of judicial review.* If a director's review is requested, the final decision shall advise the appellant or the appellant's representative of the right to judicial review by the district court. When the appellant or the appellant's representative is dissatisfied with the final decision and requests judicial review of the decision to the district court, the department shall furnish copies of the documents or supporting papers to district court, including a written transcript of the hearing. An appeal of the final decision to district court does not itself stay execution or enforcement of an agency action.

7.20(2) *Stays of agency action.*

a. Any party to a contested case proceeding may petition the director for a stay or other temporary remedies pending judicial review, of all or part of that proceeding. The petition shall state the reasons justifying a stay or other temporary remedy.

b. In determining whether to grant a stay pending judicial review, the director shall consider the factors listed in Iowa Code section 17A.19(5) "c."

c. A stay may be vacated by the director pending judicial review upon application of the department or any other party.

441—7.21(17A) Food assistance hearings and appeals.

7.21(1) *Appeal hearings.* All appeal hearings in the food assistance program shall be conducted in accordance with federal regulation, Title 7, Section 273.15, as amended to January 1, 2008.

7.21(2) *Food assistance administrative disqualification hearings.* All food assistance administrative disqualification hearings shall be conducted in accordance with federal regulation, Title 7, Section 273.16, as amended to January 1, 2008.

7.21(3) *Conduct of a food assistance administrative disqualification hearing.* Hearings over disqualification of a household member for an intentional program violation shall be conducted by a presiding officer.

a. The department of inspections and appeals shall serve an Intentional Program Violation Hearing Notice upon the household member both by certified mail, return receipt requested, and by first-class mail, postage prepaid, addressed to household member at the last-known address 30 calendar days before the initial hearing date.

b. The household member or that person's representative may request to postpone the hearing for up to 30 days, provided the request is made at least 10 calendar days before the scheduled hearing date.

c. At the hearing, the presiding officer shall advise the household member or that person's representative that the household member has the right to refuse to answer questions during the hearing and that the state or federal government may use the information in a civil or criminal action.

7.21(4) *Consolidating hearings.* Appeal hearings and food assistance administrative disqualification hearings may be consolidated if the issues arise out of the same or related circumstances, and the household member has been provided with notice of the consolidation by the department of inspections and appeals.

a. If the hearings are combined, the time frames for conducting a food assistance administrative disqualification hearing shall apply.

b. If the hearings are combined for the purpose of setting the amount of the overpayment at the same time as determining whether or not an intentional program violation has occurred, the household shall lose its right to a subsequent hearing on the amount of the overpayment.

7.21(5) *Attendance at hearing.* The household member shall be allowed ten days from the scheduled hearing to present reasons indicating good cause for not attending the hearing.

a. The appeals section shall certify the motion to vacate to the department of inspections and appeals for the presiding officer to review the motion, hold any additional proceedings, as appropriate, and determine if good cause exists for the default as specified in subrule 7.13(5). Timely filed motions

to vacate shall be granted only for good cause shown. The burden of proof as to good cause is on the moving party.

b. Unless good cause is determined, when the household member or that person's representative cannot be located or fails to appear at the scheduled hearing, the hearing shall be conducted without that person. In that instance, the presiding officer shall consider the evidence and determine if the evidence is clear and convincing that an intentional program violation was committed.

c. If the household member who failed to appear at the hearing is found to have committed an intentional program violation, but the presiding officer later determines that this person or the person's representative had good cause for not appearing, the previous hearing decision shall no longer be valid. A new hearing shall be conducted.

7.21(6) Food assistance administrative disqualification hearing decisions. The presiding officer shall base the determination of an intentional program violation on clear and convincing evidence that demonstrates the person committed, and intended to commit, an intentional program violation.

a. The proposed and final hearing decisions shall be made in accordance with rule 441—7.16(17A) unless otherwise specified.

b. The appeals section shall notify the household member and the local office of the final decision within 90 days of the date the household member is notified in writing that the hearing has been scheduled. If the hearing was postponed pursuant to subrule 7.21(3), paragraph “b,” the 90 days for notifying the household member of the final decision shall be extended for as many days as the hearing is postponed.

c. The department shall take no action to disqualify a person from receiving food assistance before receiving the final appeal decision finding that the person has committed an intentional program violation.

d. No further administrative appeal procedure shall exist after the final decision is issued. The determination of an intentional program violation shall not be reversed by a subsequent hearing decision. However, the person may appeal the case to the Iowa district court.

e. When a court decision reverses a determination of an intentional program violation, the appeals section shall notify the local office of the specifics of the court decision.

[ARC 8003B, IAB 7/29/09, effective 9/2/09]

441—7.22(17A) FIP disqualification hearings. Rescinded IAB 4/30/03, effective 7/1/03.

441—7.23(17A) Contested cases with no factual dispute. If the parties in a contested case agree that there is no dispute of material fact, the parties may present all admissible evidence either by stipulation, or as otherwise agreed, in lieu of an evidentiary hearing. If an agreement is reached, the parties shall jointly submit a schedule for submission of the record, briefs and oral arguments to the presiding officer for approval.

441—7.24(17A) Emergency adjudicative proceedings.

7.24(1) Necessary emergency action. To the extent necessary to prevent or avoid immediate danger to the public health, safety, or welfare, and consistent with the United States Constitution and the Iowa Constitution and other provisions of law, the department may issue a written order in compliance with Iowa Code section 17A.18 to suspend a license in whole or in part, order the cessation of any continuing activity, order affirmative action, or take other action within the jurisdiction of the department by emergency adjudicative order. Before issuing an emergency adjudicative order, the department shall consider factors including, but not limited to, the following:

a. Whether there has been sufficient factual investigation to ensure that the agency is proceeding on the basis of reliable information.

b. Whether the specific circumstances which pose immediate danger to the public health, safety or welfare have been identified and determined to be continuing.

c. Whether the person required to comply with the emergency adjudicative order may continue to engage in other activities without posing immediate danger to the public health, safety or welfare.

d. Whether imposition of monitoring requirements or other interim safeguards would be sufficient to protect the public health, safety or welfare.

e. Whether the specific action contemplated by the agency is necessary to avoid the immediate danger.

7.24(2) Issuance of order.

a. An emergency adjudicative order shall contain findings of fact, conclusions of law, and policy reasons to justify the determination of an immediate danger and the department's decision to take immediate action.

b. The written emergency adjudicative order shall be immediately delivered to persons who are required to comply with the order by using one or more of the following procedures:

- (1) Personal delivery.
- (2) Certified mail, return receipt requested, to the last address on file with the department.
- (3) Certified mail to the last address on file with the department.
- (4) First-class mail to the last address on file with the department.
- (5) Fax. Fax may be used as the sole method of delivery if the person required to comply with the order has filed a written request that department orders be sent by fax and has provided a fax number for that purpose.

c. To the degree practicable, the agency shall select the procedure for providing written notice that best ensures prompt, reliable delivery.

7.24(3) Oral notice. Unless the written emergency adjudicative order is provided by personal delivery on the same day that the order issues, the department shall make reasonable immediate efforts to contact by telephone the persons who are required to comply with the order.

7.24(4) Completion of proceedings. After the issuance of an emergency adjudicative order, the agency shall proceed as quickly as feasible to complete any proceedings that would be required if the matter did not involve an immediate danger. Issuance of a written emergency adjudicative order shall include notification of the date on which agency proceedings are scheduled for completion. After issuance of an emergency adjudicative order, continuance of further agency proceedings to a later date will be granted only in compelling circumstances upon application in writing.

441—7.25 to 7.40 Reserved.

DIVISION II

APPEALS BASED ON THE COMPETITIVE PROCUREMENT BID PROCESS

441—7.41(17A) Scope and applicability. The rules in Division II apply to appeals based on the department's competitive procurement bid process.

[ARC 1206C, IAB 12/11/13, effective 1/15/14]

441—7.42(17A) Requests for timely filing of an appeal. Any bidder that receives either a notice of disqualification or a notice of award, and has first exhausted the reconsideration process, is considered an aggrieved party and may file a written appeal with the department.

7.42(1) An aggrieved party in a competitive procurement must seek reconsideration of a disqualification or a notice of award prior to filing any appeal. The request for reconsideration must be received by the department within five days of the date of either a disqualification notice or notice of award. The department will expeditiously address the request for reconsideration and issue a decision on the reconsideration. If the party seeking reconsideration continues to be an aggrieved party following receipt of the decision on reconsideration, the aggrieved party may file an appeal within five days of the date of the department's decision on reconsideration.

7.42(2) The written appeal shall state the grounds upon which the appellant challenges the department's decision.

7.42(3) The day after the department's decision on reconsideration is issued is the first day of the period in which the appeal may be filed. The mailing address is: Department of Human Services, Appeals

Section, 1305 East Walnut Street, Des Moines, Iowa 50319-0114. Appeals may also be sent by fax, e-mail, or in-person delivery.

[ARC 1206C, IAB 12/11/13, effective 1/15/14]

441—7.43(17A) Bidder appeals. The bidder appeal shall be a contested case proceeding and shall be conducted in accordance with the provisions of Division II. Division I of this chapter does not apply to competitive procurement bid appeals, unless otherwise noted.

7.43(1) Hearing time frame. The presiding officer shall hold a hearing on the bidder appeal within 60 days of the date the notice of appeal was received by the department.

7.43(2) Registration. Upon receipt of the notice of appeal, the department shall register the appeal.

7.43(3) Acknowledgment. Upon receipt of the notice of appeal, the department shall send a written acknowledgment of receipt of the appeal to the appellant, representative, or both. The appropriate department staff will be notified of the appeal.

7.43(4) Granting a hearing. The department shall determine whether an appellant may be granted a hearing and the issues to be discussed at the hearing in accordance with the applicable rules, statutes or federal regulations or request for proposal.

a. The appeals of those appellants who are granted a hearing shall be certified to the department of inspections and appeals for the hearing to be conducted. The department shall indicate at the time of certification the issues to be discussed at the hearing.

b. Appeals of those appellants that are denied a hearing shall not be closed until a letter is sent to the appellant and the appellant's representative advising of the denial of the hearing and the basis upon which that denial is made. Any appellant that disagrees with a denial may present additional information relative to the reason for denial and request reconsideration by the department over the denial.

7.43(5) Hearing scheduled. For those records certified for hearing, the department of inspections and appeals shall establish the date, time, method and place of the hearing, with due regard for the convenience of the appellant as set forth in the department of inspections and appeals rules in 481—Chapter 10 unless otherwise designated by federal or state statute or regulation.

7.43(6) Method of hearing. The department of inspections and appeals shall determine whether the appeal hearing is to be conducted in person, by videoconference or by teleconference call. The parties to the appeal may participate from multiple sites for videoconference or teleconference hearings. Any appellant is entitled to an in-person hearing if the appellant requests one. All parties shall be granted the same rights during a teleconference hearing as specified in rule 441—7.13(17A).

7.43(7) Reschedule requests. Requests made by the appellant or the department to set another date, time, method or place of hearing shall be made to the department of inspections and appeals, except as otherwise noted. The granting of the requests will be at the discretion of the department of inspections and appeals. All requests concerning the scheduling of a hearing shall be made to the department of inspections and appeals directly.

7.43(8) Notification. For those appeals certified for hearing, the department of inspections and appeals shall send a notice to the appellant at least ten calendar days in advance of the hearing date.

a. The notice shall comply with Iowa Code section 17A.12(2), and include a statement that opportunity shall be afforded to all parties to respond and present evidence on all issues involved and to be represented by counsel at their own expense.

b. A copy of this notice shall be made available to the department employee who took the action and to any other parties to the appeal.

[ARC 1206C, IAB 12/11/13, effective 1/15/14]

441—7.44(17A) Procedures for bidder appeal.

7.44(1) Discovery. The parties shall serve any discovery requests upon other parties at least 30 days prior to the date set for the hearing. The parties must serve responses to discovery at least 15 days prior to the date set for the hearing.

7.44(2) Witnesses and exhibits. The parties shall contact each other regarding witnesses and exhibits at least ten days prior to the date set for the hearing. The parties must meet prior to the hearing regarding the evidence to be presented in order to avoid duplication or the submission of extraneous materials.

7.44(3) Amendments to notice of appeal. The aggrieved bidder may amend the grounds upon which the bidder challenges the department's award no later than 15 days prior to the date set for the hearing.

7.44(4) If the hearing is not conducted in person, the parties must deliver all exhibits to the office of the presiding officer at least three days prior to the time the hearing is conducted.

7.44(5) The presiding officer shall issue a proposed decision in writing that includes findings of fact and conclusions of law stated separately. The decision shall be based on the record of the contested case and shall conform to Iowa Code chapter 17A. The presiding officer shall send the proposed decision to the appellant and representative by mail.

7.44(6) The record of the contested case shall include all materials specified in Iowa Code subsection 17A.12(6).

[ARC 1206C, IAB 12/11/13, effective 1/15/14]

441—7.45(17A) Stay of agency action for bidder appeal.

7.45(1) *When a stay may be requested.*

a. Any party appealing the issuance of a notice of disqualification or notice of award may petition for stay of the decision pending its review. The petition for stay shall be filed with the notice of appeal, shall state the reasons justifying a stay, and shall be accompanied by an appeal bond equal to 120 percent of the contract value.

b. Any party adversely affected by a final decision and order may petition the department for a stay of that decision and order pending judicial review. The petition for stay shall be filed with the director within five days of receipt of the final decision and order and shall state the reasons justifying a stay.

7.45(2) *When a stay is granted.* In determining whether to grant a stay, the director shall consider the factors listed in Iowa Code section 17A.19(5) "c."

7.45(3) *Vacation.* A stay may be vacated by the issuing authority upon application of the department or any other party.

[ARC 1206C, IAB 12/11/13, effective 1/15/14]

441—7.46(17A) Request for review of the proposed decision. A request for review of the proposed decision shall follow the provisions outlined in subrules 7.16(5) to 7.16(7).

[ARC 1206C, IAB 12/11/13, effective 1/15/14]

441—7.47(17A) Other procedural considerations.

7.47(1) *Consolidation—severance.*

a. Consolidation. The presiding officer may, upon motion by any party or the presiding officer's own motion, consolidate any or all matters at issue in two or more contested case proceedings where:

- (1) The matters at issue involve common parties or common questions of fact or law;
- (2) Consolidation would expedite and simplify consideration of the issues; and
- (3) Consolidation would not adversely affect the rights of parties to those proceedings.

At any time prior to the hearing, any party may on motion request that the matters not be consolidated, and the motion shall be granted for good cause shown.

b. Severance. The presiding officer may, upon motion by any party or upon the presiding officer's own motion, for good cause shown, order any proceeding or portion thereof severed.

7.47(2) *Presiding officer.* Appeal hearings shall be conducted by an administrative law judge appointed by the department of inspections and appeals pursuant to rule 441—7.3(17A).

7.47(3) *Rights of appellants during hearings.* All rights afforded appellants at rule 441—7.13(17A) shall apply.

[ARC 1206C, IAB 12/11/13, effective 1/15/14]

441—7.48(17A) Appeal record.

7.48(1) The appeal record shall consist of all items specified in subrule 7.16(1).

7.48(2) The party that requests a transcription of the proceedings shall bear the cost.

[ARC 1206C, IAB 12/11/13, effective 1/15/14]

441—7.49(17A) Pleadings.

7.49(1) Pleadings may be required by rule, by the notice of hearing or by order of the presiding officer.

7.49(2) Petition. When an action of the department is appealed and pleadings are required under subrule 7.49(1), the aggrieved party shall file the petition.

a. Any required petition shall be filed within 20 days of delivery of the notice of hearing, unless otherwise ordered.

b. The petition shall state in separately numbered paragraphs the following:

- (1) On whose behalf the petition is filed;
- (2) The particular provisions of the statutes and rules involved;
- (3) The relief demanded and the facts and law relied upon for relief; and
- (4) The name, address and telephone number of the petitioner and the petitioner's attorney, if any.

7.49(3) Answer. If pleadings are required, the answer shall be filed within 20 days of service of the petition or notice of hearing, unless otherwise ordered.

a. Any party may move to dismiss or apply for a more definite, detailed statement when appropriate.

b. The answer shall show on whose behalf it is filed and specifically admit, deny or otherwise answer all material allegations of the pleading to which it responds. It shall state any facts deemed to show an affirmative defense and may contain as many defenses as the pleader may claim.

c. The answer shall state the name, address and telephone number of the person filing the answer and of the attorney representing that person, if any.

d. Any allegation in the petition not denied in the answer is considered admitted. The presiding officer may refuse to consider any defense not raised in the answer which could have been raised on the basis of facts known when the answer was filed if any party would be prejudiced.

7.49(4) Amendment. Any notice of hearing, petition or other charging document may be amended before a responsive pleading has been filed. Amendments to pleadings after a responsive pleading has been filed and to an answer may be allowed with the consent of the other parties or in the discretion of the presiding officer who may impose terms or grant a continuance.

[ARC 1206C, IAB 12/11/13, effective 1/15/14]

441—7.50(17A) Ex parte communications. The rules regarding ex parte communications listed at 441—7.18(17A) apply.

[ARC 1206C, IAB 12/11/13, effective 1/15/14]

441—7.51(17A) Right of judicial review. The rules regarding right of judicial review listed at 441—7.20(17A) apply.

[ARC 1206C, IAB 12/11/13, effective 1/15/14]

These rules are intended to implement Iowa Code chapter 17A.

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CHAPTER 41
GRANTING ASSISTANCE
[Prior to 7/1/83, Social Services[770] Ch 41]
[Prior to 2/11/87, Human Services[498]]

DIVISION I
FAMILY INVESTMENT PROGRAM—
CONTROL GROUP
[Rescinded IAB 2/12/97, effective 3/1/97]

441—41.1 to 41.20 Reserved.

DIVISION II
FAMILY INVESTMENT PROGRAM—TREATMENT GROUP
[Prior to 10/13/93, Human Services(441—41.1 to 41.9)]

441—41.21(239B) Eligibility factors specific to child.

41.21(1) Age. The family investment program shall be available to a needy child under the age of 18 years without regard to school attendance.

A child is eligible for the entire month in which the child's eighteenth birthday occurs, unless the birthday falls on the first day of the month. The family investment program shall also be available to a needy child of 18 years who is a full-time student in a secondary school, or in the equivalent level of vocational or technical training, as defined in paragraph 41.24(2) "e," and who is reasonably expected to complete the program before reaching the age of 19.

41.21(2) Rescinded, effective June 1, 1988.

41.21(3) Residing with relative. The child shall be living in the home of one of the relatives specified in subrule 41.22(3). When an unwed mother intends to place her child for adoption shortly after birth, the child shall be considered as living with the mother until the time custody is actually relinquished.

a. Living with relatives implies primarily the existence of a relationship involving an accepted responsibility on the part of the relative for the child's welfare, including the sharing of a common household.

b. Home is the family setting maintained or in the process of being established as evidenced by the assumption and continuation of responsibility for the child by the relative.

41.21(4) Rescinded, effective July 1, 1980.

41.21(5) Deprivation of parental care and support. Rescinded IAB 11/1/00, effective 1/1/01.

This rule is intended to implement Iowa Code sections 239B.1, 239B.2 and 239B.5.

441—41.22(239B) Eligibility factors specific to payee.

41.22(1) Reserved.

41.22(2) Rescinded, effective June 1, 1988.

41.22(3) Specified relationship.

a. A child may be considered as meeting the requirement of living with a specified relative if the child's home is with one of the following or with a spouse of the relative even though the marriage is terminated by death or divorce:

Father—adoptive father.

Mother—adoptive mother.

Grandfather—grandfather-in-law, meaning the subsequent husband of the child's natural grandmother, i.e., stepgrandfather—adoptive grandfather.

Grandmother—grandmother-in-law, meaning the subsequent wife of the child's natural grandfather, i.e., stepgrandmother—adoptive grandmother.

Great-grandfather—great-great-grandfather.

Great-grandmother—great-great-grandmother.

Stepfather, but not his parents.

Stepmother, but not her parents.

Brother—brother-of-half-blood—stepbrother—brother-in-law—adoptive brother.

Sister—sister-of-half-blood—stepsister—sister-in-law—adoptive sister.

Uncle—aunt, of whole or half blood.

Uncle-in-law—aunt-in-law.

Great uncle—great-great-uncle.

Great aunt—great-great-aunt.

First cousins—nephews—nieces.

Second cousins, meaning the son or daughter of one's parent's first cousin.

b. A relative of the putative father can qualify as a specified relative if the putative father has acknowledged paternity by the type of written evidence on which a prudent person would rely.

c. The family investment program is available to a child of unmarried parents the same as to a child of married parents when all eligibility factors are met.

d. The presence of an able-bodied stepparent in the home shall not disqualify a child for assistance, provided that other eligibility factors are met.

41.22(4) *Liability of relatives.* All appropriate steps shall be taken to secure support from legally liable persons on behalf of all persons in the eligible group, including the establishment of paternity.

a. When necessary to establish eligibility, the income maintenance unit shall make the initial contact with the absent parent at the time of application. Subsequent contacts shall be made by the child support recovery unit.

b. When contact with the family investment program family or other sources of information indicate that relatives other than parents and spouses of the eligible children are contributing toward the support of members of the eligible group, have contributed in the past, or are of such financial standing they might reasonably be expected to contribute, the income maintenance unit shall contact these persons to verify current contributions or arrange for contributions on a voluntary basis.

41.22(5) *Referral to child support recovery unit.* The income maintenance unit shall provide prompt notice to the child support recovery unit whenever assistance is furnished with respect to a child with a parent who is absent from the home or when any member of the eligible group is entitled to support payments.

a. A referral to the child support recovery unit shall not be made when a parent's absence is occasioned solely by reason of the performance of active duty in the uniformed services of the United States. "Uniformed service" means the Army, Navy, Air Force, Marine Corps, Coast Guard, National Oceanographic and Atmospheric Administration, or Public Health Service of the United States.

b. "Prompt notice" means within two working days of the date assistance is approved.

41.22(6) *Cooperation in obtaining support.* Each applicant for or recipient of the family investment program shall cooperate with the department in establishing paternity and securing support for persons whose needs are included in the assistance grant, except when good cause as defined in 41.22(8) for refusal to cooperate is established.

a. The applicant or recipient shall cooperate in the following areas:

(1) Identifying and locating the parent of the child for whom aid is claimed.

(2) Establishing the paternity of a child born out of wedlock for whom aid is claimed.

(3) Obtaining support payments for the applicant or recipient and for a child for whom aid is claimed.

(4) Rescinded IAB 12/3/97, effective 2/1/98.

b. Cooperation is defined as including the following actions by the applicant or recipient:

(1) Appearing at the office of the income maintenance unit or the child support recovery unit to provide verbal or written information or documentary evidence known to, possessed by, or reasonably obtained by the applicant or recipient that is relevant to achieving the objectives of the child support recovery program.

(2) Appearing as a witness at judicial or other hearings or proceedings.

(3) Providing information, or attesting to the lack of information, under penalty of perjury.

(4) Paying to the department any cash support payments for a member of the eligible group, except as described at 41.27(7) “p” and “q,” received by a recipient after the date of decision as defined in 441—subrule 40.24(4).

(5) Providing the name of the absent parent and additional necessary information.

c. The applicant or recipient shall cooperate with the income maintenance unit in supplying information with respect to the absent parent, the receipt of support, and the establishment of paternity, to the extent necessary to establish eligibility for assistance and permit an appropriate referral to the child support recovery unit.

d. The applicant or recipient shall cooperate with the child support recovery unit to the extent of supplying all known information and documents pertaining to the location of the absent parent and taking action as may be necessary to secure or enforce a support obligation or establish paternity. This includes completing and signing documents determined to be necessary by the state’s attorney for any relevant judicial or administrative process.

e. In the circumstance as described at paragraph “b,” subparagraph (4), the income maintenance unit shall make the determination of whether or not the applicant or recipient has cooperated. In all other instances, the child support recovery unit shall make the determination of whether the applicant or recipient has cooperated. The child support recovery unit delegates the income maintenance unit to make this determination for applicants.

f. Failure to cooperate shall result in a sanction to the family. The sanction shall be a deduction of 25 percent from the net cash assistance grant amount payable to the family before any deduction for recoupment of a prior overpayment.

(1) When the income maintenance unit determines noncooperation, the sanction shall be implemented after the noncooperation has occurred. The sanction shall remain in effect until the client has expressed willingness to cooperate. However, any action to remove the sanction shall be delayed until cooperation has occurred.

(2) When the child support recovery unit (CSRU) makes the determination, the sanction shall be implemented upon notification from CSRU to the income maintenance unit that the client has failed to cooperate. The sanction shall remain in effect until the client has expressed to either income maintenance or CSRU staff willingness to cooperate. However, any action to remove the sanction shall be delayed until income maintenance is notified by CSRU that the client has cooperated.

41.22(7) Assignment of support payments. Each applicant for or recipient of assistance shall assign to the department any rights to support from any other person that the applicant or recipient may have. The assignment of support payments shall include rights to support in the applicant’s or recipient’s own behalf or in behalf of any other family member for whom the applicant or recipient is applying or receiving assistance.

a. The assignment of support payments shall include rights to all support payments that accrue during the period of assistance but shall not exceed the total amount of assistance received.

b. An assignment is effective the same date all eligibility information is entered into the department’s computer system and is effective for the entire period for which assistance is paid.

41.22(8) Good cause for refusal to cooperate. Good cause shall exist when it is determined that cooperation in establishing paternity and securing support is against the best interests of the child.

a. The income maintenance unit shall determine that cooperation is against the child’s best interest when the applicant’s or recipient’s cooperation in establishing paternity or securing support is reasonably anticipated to result in:

- (1) Physical harm to the child for whom support is to be sought; or
- (2) Emotional harm to the child for whom support is to be sought; or
- (3) Physical harm to the parent or caretaker relative with whom the child is living which reduces the person’s capacity to care for the child adequately; or
- (4) Emotional harm to the parent or caretaker relative with whom the child is living of a nature or degree that it reduces the person’s capacity to care for the child adequately.

b. The income maintenance unit shall determine that cooperation is against the child’s best interest when at least one of the following circumstances exists, and the income maintenance unit believes that

because of the existence of that circumstance, in the particular case, proceeding to establish paternity or secure support would be detrimental to the child for whom support would be sought.

- (1) The child for whom support is sought was conceived as a result of incest or forcible rape.
- (2) Legal proceedings for the adoption of the child are pending before a court of competent jurisdiction.
- (3) The applicant or recipient is currently being assisted by a public or licensed private social agency to resolve the issue of whether to keep the child or relinquish the child for adoption, and the discussions have not gone on for more than three months.

c. Physical harm and emotional harm shall be of a serious nature in order to justify a finding of good cause. A finding of good cause for emotional harm shall be based only upon a demonstration of an emotional impairment that substantially affects the individual's functioning.

d. When the good cause determination is based in whole or in part upon the anticipation of emotional harm to the child, the parent, or the caretaker relative, the following shall be considered:

- (1) The present emotional state of the individual subject to emotional harm.
- (2) The emotional health history of the individual subject to emotional harm.
- (3) Intensity and probable duration of the emotional impairment.
- (4) The degree of cooperation required.
- (5) The extent of involvement of the child in the paternity establishment or support enforcement activity to be undertaken.

41.22(9) *Claiming good cause.* Each applicant for or recipient of the family investment program who is required to cooperate with the child support recovery unit shall have the opportunity to claim good cause for refusing to cooperate in establishing paternity or securing support payments.

a. Before requiring cooperation, the income maintenance unit shall notify the applicant or recipient using Form 470-0169, Requirements of Support Enforcement, of the right to claim good cause as an exception to the cooperation requirement and of all the requirements applicable to a good cause determination.

b. The initial notice advising of the right to refuse to cooperate for good cause shall:

- (1) Advise the applicant or recipient of the potential benefits the child may derive from the establishment of paternity and securing support.
- (2) Advise the applicant or recipient that by law cooperation in establishing paternity and securing support is a condition of eligibility for the family investment program.
- (3) Advise the applicant or recipient of the sanctions provided for refusal to cooperate without good cause.
- (4) Advise the applicant or recipient that good cause for refusal to cooperate may be claimed; and that if the income maintenance unit determines, in accordance with these rules, that there is good cause, the applicant or recipient will be excused from the cooperation requirement.
- (5) Advise the applicant or recipient that upon request, or following a claim of good cause, the income maintenance unit will provide further notice with additional details concerning good cause.

c. When the applicant or recipient makes a claim of good cause or requests additional information regarding the right to file a claim of good cause, the income maintenance unit shall issue a second notice, Form 470-0170, Requirements of Claiming Good Cause. To claim good cause, the applicant or recipient shall sign and date Form 470-0170 and return it to the income maintenance unit. This form:

- (1) Indicates that the applicant or recipient must provide corroborative evidence of a good cause circumstance and must, when requested, furnish sufficient information to permit the income maintenance unit to investigate the circumstances.
- (2) Informs the applicant or recipient that, upon request, the income maintenance unit will provide reasonable assistance in obtaining the corroborative evidence.
- (3) Informs the applicant or recipient that on the basis of the corroborative evidence supplied and the department's investigation when necessary, the income maintenance unit will determine whether cooperation would be against the best interest of the child for whom support would be sought.
- (4) Lists the circumstances under which cooperation may be determined to be against the best interests of the child.

(5) Informs the applicant or recipient that the child support recovery unit may review the income maintenance unit's findings and basis for a good cause determination and may participate in any hearings concerning the issue of good cause.

(6) Informs the applicant or recipient that the child support recovery unit may attempt to establish paternity and collect support in those cases where the income maintenance unit determines that this can be done without risk to the applicant or recipient if done without the applicant's or recipient's participation.

d. The applicant or recipient who refuses to cooperate and who claims to have good cause for refusing to cooperate has the burden of establishing the existence of a good cause circumstance. Failure to meet these requirements shall constitute a sufficient basis for the income maintenance unit to determine that good cause does not exist. The applicant or recipient shall:

(1) Specify the circumstances that the applicant or recipient believes provide sufficient good cause for not cooperating.

(2) Corroborate the good cause circumstances.

(3) When requested, provide sufficient information to permit an investigation.

41.22(10) *Determination of good cause.* The income maintenance unit shall determine whether good cause exists for each applicant for or recipient of the family investment program who claims to have good cause.

a. The applicant or recipient shall be notified by the income maintenance unit of its determination that good cause does or does not exist. The determination shall:

(1) Be in writing.

(2) Contain the income maintenance unit's findings and basis for determination.

(3) Be entered in the family investment program case record.

b. The determination of whether or not good cause exists shall be made within 45 days from the day the good cause claim is made. The income maintenance unit may exceed this time standard only when:

(1) The case record documents that the income maintenance unit needs additional time because the information required to verify the claim cannot be obtained within the time standard, or

(2) The case record documents that the claimant did not provide corroborative evidence within the time period set forth in 41.22(11).

c. When the income maintenance unit determines that good cause does not exist:

(1) The applicant or recipient will be so notified and afforded an opportunity to cooperate, withdraw the application for assistance, or have the case closed; and

(2) Continued refusal to cooperate will result in the imposition of sanctions.

d. The income maintenance unit shall make a good cause determination based on the corroborative evidence supplied by the applicant or recipient only after the unit has examined the evidence and found that it actually verifies the good cause claim.

e. Before making a final determination of good cause for refusing to cooperate, the income maintenance unit shall:

(1) Afford the child support recovery unit the opportunity to review and comment on the findings and basis for the proposed determination, and

(2) Consider any recommendation from the child support recovery unit.

f. The child support recovery unit may participate in any appeal hearing that results from an applicant's or recipient's appeal of an agency action with respect to a decision on a claim of good cause.

g. Assistance shall not be denied, delayed, or discontinued pending a determination of good cause for refusal to cooperate when the applicant or recipient has specified the circumstances under which good cause can be claimed and provided the corroborative evidence and any additional information needed to establish good cause.

h. The income maintenance unit shall:

(1) Periodically, but not less frequently than every six months, review those cases in which the agency has determined that good cause exists based on a circumstance that is subject to change.

(2) When it determines that circumstances have changed so that good cause no longer exists, rescind its findings and proceed to enforce the requirements pertaining to cooperation in establishing paternity and securing support.

41.22(11) *Proof of good cause.* The applicant or recipient who claims good cause shall provide corroborative evidence within 20 days from the day the claim was made. In exceptional cases where the income maintenance unit determines that the applicant or recipient requires additional time because of the difficulty in obtaining the corroborative evidence, the income maintenance unit shall allow a reasonable additional period upon approval by the worker's immediate supervisor.

a. A good cause claim may be corroborated with the following types of evidence.

(1) Birth certificates or medical or law enforcement records which indicate that the child was conceived as the result of incest or forcible rape.

(2) Court documents or other records which indicate that legal proceedings for adoption are pending before a court of competent jurisdiction.

(3) Court, medical, criminal, child protective services, social services, psychological, or law enforcement records which indicate that the putative father or absent parent might inflict physical or emotional harm on the child or caretaker relative.

(4) Medical records which indicate emotional health history and present emotional health status of the caretaker relative or the child for whom support would be sought; or written statements from a mental health professional indicating a diagnosis or prognosis concerning the emotional health of the caretaker relative or the child for whom support would be sought.

(5) A written statement from a public or licensed private social agency that the applicant or recipient is being assisted by the agency to resolve the issue of whether to keep the child or relinquish the child for adoption.

(6) Sworn statements from individuals other than the applicant or recipient with knowledge of the circumstances which provide the basis for the good cause claim.

b. When, after examining the corroborative evidence submitted by the applicant or recipient, the income maintenance unit wishes to request additional corroborative evidence which is needed to permit a good cause determination, the income maintenance unit shall:

(1) Promptly notify the applicant or recipient that additional corroborative evidence is needed, and

(2) Specify the type of document which is needed.

c. When the applicant or recipient requests assistance in securing corroborative evidence, the income maintenance unit shall:

(1) Advise the applicant or recipient how to obtain the necessary documents, and

(2) Make a reasonable effort to obtain any specific documents which the applicant or recipient is not reasonably able to obtain without assistance.

d. When a claim is based on the applicant's or recipient's anticipation of physical harm and corroborative evidence is not submitted in support of the claim:

(1) The income maintenance unit will investigate the good cause claim when the unit believes that the claim is credible without corroborative evidence and corroborative evidence is not available.

(2) Good cause will be found when the claimant's statement and investigation which is conducted satisfies the income maintenance unit that the applicant or recipient has good cause for refusing to cooperate.

(3) A determination that good cause exists will be reviewed and approved or disapproved by the worker's immediate supervisor and the findings will be recorded in the case record.

e. The income maintenance unit may further verify the good cause claim when the applicant's or recipient's statement of the claim together with the corroborative evidence do not provide sufficient basis for making a determination. When the income maintenance unit determines that it is necessary, the unit may conduct an investigation of good cause claims to determine that good cause does or does not exist.

f. When it conducts an investigation of a good cause claim, the income maintenance unit will:

(1) Contact the absent parent or putative father from whom support would be sought when the contact is determined to be necessary to establish the good cause claim.

(2) Prior to making the necessary contact, notify the applicant or recipient so the applicant or recipient may present additional corroborative evidence or information so that contact with the parent or putative father becomes unnecessary, withdraw the application for assistance or have the case closed, or have the good cause claim denied.

41.22(12) *Enforcement without caretaker's cooperation.* When the income maintenance unit makes a determination that good cause exists, the unit shall also make a determination of whether or not child support enforcement can proceed without risk of harm to the child or caretaker relative when the enforcement or collection activities do not involve the participation of the child or caretaker.

a. The child support recovery unit shall have an opportunity to review and comment on the findings and basis for the proposed determination, and the income maintenance unit shall consider any recommendation from the child support recovery unit.

b. The determination shall:

- (1) Be in writing,
- (2) Contain the income maintenance unit's findings and basis for determination, and
- (3) Be entered into the family investment program case record.

c. When the income maintenance unit excuses cooperation but determines that the child support recovery unit may proceed to establish paternity or enforce support, the income maintenance unit will notify the applicant or recipient to enable the individual to withdraw the application for assistance or have the case closed.

41.22(13) *Furnishing of social security number.* As a condition of eligibility each applicant for or recipient of and all members of the eligible group must furnish a social security account number or proof of application for a number if it has not been issued or is not known and provide the number upon its receipt. The requirement shall not apply to a payee who is not a member of the eligible group.

a. Assistance shall not be denied, delayed, or discontinued pending the issuance or verification of the numbers when the applicant or recipient has complied with the requirements of 41.22(13).

b. When the mother of the newborn child is a current recipient, the mother shall have until the second month following the mother's discharge from the hospital to apply for a social security account number for the child.

c. When the applicant is a battered alien, as described at 41.23(4), the applicant shall have until the month following the month the person receives employment authorization from the Immigration and Naturalization Service to apply for a social security account number.

41.22(14) *Department of workforce development registration and referral.* Rescinded IAB 11/1/00, effective 1/1/01.

41.22(15) *Requiring minor parents to live with parent or legal guardian.* A minor parent and the dependent child in the minor parent's care must live in the home of a parent or legal guardian of the minor parent in order to receive family investment program benefits unless good cause for not living with the parent or legal guardian is established.

a. "Living in the home" includes living in the same apartment, same half of a duplex, same condominium or same row house as the adult parent or legal guardian. It also includes living in an apartment which is located in the home of the adult parent or legal guardian.

b. For applicants, determination of whether the minor parent and child are living with a parent or legal guardian or have good cause must be made as of the date of the first application interview as described at 441—subrule 40.24(2).

(1) If, as of the date of this interview, the minor parent and child are living with a parent or legal guardian or are determined to have good cause, the FIP application for the minor parent and child shall be approved as early as seven days from receipt of the application provided they are otherwise eligible.

(2) If, as of the date of this interview, the minor parent and child are not living with a parent or legal guardian and do not have good cause, the FIP application for the minor parent and child shall be denied.

c. For recipients, when changes occur, continuing eligibility shall be redetermined according to 441—subrules 40.27(4) and 40.27(5).

d. A minor parent determined to have good cause for not living with a parent or legal guardian must attend FaDSS or other family development as required in 441—subrule 93.4(4).

41.22(16) *Good cause for not living in the home of a parent or legal guardian.* Good cause shall exist when at least one of the following conditions applies:

- a. The parents or legal guardian of the minor parent is deceased, missing or living in another state.
- b. The physical or emotional health or safety of the minor parent or child would be jeopardized if the minor parent is required to live with the parent or legal guardian.

(1) Physical or emotional harm shall be of a serious nature in order to justify a finding of good cause.

(2) Physical or emotional harm shall include situations of documented abuse or incest.

(3) When the good cause determination is based in whole or in part upon the anticipation of emotional harm to the minor parent or child, the following shall be considered:

- 1. The present emotional state of the individual subject to emotional harm.
- 2. The emotional health history of the individual subject to emotional harm.
- 3. Intensity and probable duration of the emotional impairment.
- c. The minor parent is in a foster care supervised apartment living arrangement.
- d. The minor parent is participating in the job corps solo parent program.
- e. The parents or legal guardian refuses to allow the minor parent and child to return home and the minor parent is living with a specified relative, aged 21 or over, on the day of interview, and the caretaker is the applicant or payee.

f. The minor parent and child live in a maternity home or other licensed adult-supervised supportive living arrangement as defined by the department of human services.

g. Other circumstances exist which indicate that living with the parents or legal guardian will defeat the goals of self-sufficiency and responsible parenting. Situations which appear to meet this good cause reason must be referred to the administrator of the division of economic assistance, or the administrator's designee, for determination of good cause.

41.22(17) *Claiming good cause for not living in the home of a parent or legal guardian.* Each applicant or recipient who is not living with a parent or legal guardian shall have the opportunity to claim good cause for not living with a parent or legal guardian.

41.22(18) *Determination of good cause for not living in the home of a parent or legal guardian.* The department shall determine whether good cause exists for each applicant or recipient who claims good cause.

a. The applicant or recipient shall be notified by the department of its determination that good cause does or does not exist. The determination shall:

- (1) Be in writing.
- (2) Contain the department's findings and basis for determination.
- (3) Be entered in the family investment program case record.
- b. When the department determines that good cause does not exist:

- (1) The applicant or recipient shall be so notified.
- (2) The application shall be denied or family investment program assistance canceled.
- (3) Rescinded IAB 8/31/05, effective 11/1/05.

c. The department shall:

(1) Periodically, but not less frequently than every six months, review those cases in which the agency has determined that good cause exists based on a circumstance that is subject to change.

(2) When it determines that circumstances have changed so that good cause no longer exists, rescind its findings and proceed to enforce the requirements.

41.22(19) *Proof of good cause for not living in the home of a parent or legal guardian.* The applicant or recipient who claims good cause shall provide corroborative evidence to prove the good cause claim within the time frames described at 441—subrule 40.24(1) and paragraph 40.27(4)“c.”

a. A good cause claim may be corroborated by one or more of the following types of evidence:

(1) Court, medical, criminal, child protective services, social services, psychological, or law enforcement records which indicate that the parent or legal guardian might inflict physical or emotional harm on the minor parent or child.

(2) Medical records that indicate the emotional health history and present emotional health status of the minor parent or child; or written statements from a mental health professional indicating a diagnosis or prognosis concerning the emotional health of the minor parent or child.

(3) Sworn statements from individuals other than the applicant or recipient with knowledge of the circumstances which provide the basis for the good cause claim. Written statements from the client's friends or relatives are not sufficient alone to grant good cause based on physical or emotional harm, but may be used to support other evidence.

(4) Notarized statements from the parents or legal guardian or other reliable evidence to verify that the parents or legal guardian refuse to allow the minor parent and child to return home.

(5) Court, criminal, child protective services, social services or other records which verify that the parents or legal guardian of the minor parent is deceased, missing or living in another state, or that the minor parent is in a foster care supervised apartment living arrangement, the job corps solo parent program, maternity home or other licensed adult-supervised supportive living arrangement.

b. When, after examining the corroborative evidence submitted by the applicant or recipient, the department wishes to request additional corroborative evidence which is needed to permit a good cause determination, the department shall:

(1) Promptly notify the applicant or recipient that additional corroborative evidence is needed.

(2) Specify the type of document which is needed.

c. When the applicant or recipient requests assistance in securing evidence, the department shall:

(1) Advise the applicant or recipient how to obtain the necessary documents.

(2) Make a reasonable effort to obtain any specific documents which the applicant or recipient is not reasonably able to obtain without assistance.

This rule is intended to implement Iowa Code chapter 239B.

[ARC 8004B, IAB 7/29/09, effective 10/1/09]

441—41.23(239B) Home, residence, citizenship, and alienage.

41.23(1) *Iowa residence.*

a. A resident of Iowa is one:

(1) Who is living in Iowa voluntarily with the intention of making that person's home there and not for a temporary purpose. A child is a resident of Iowa when living there on other than a temporary basis. Residence may not depend upon the reason for which the individual entered the state, except insofar as it may bear upon whether the individual is there voluntarily or for a temporary purpose; or

(2) Who, at the time of application, is living in Iowa, is not receiving assistance from another state, and entered Iowa with a job commitment or seeking employment in Iowa, whether or not currently employed. Under this definition the child is a resident of the state in which the caretaker is a resident.

b. Residence is retained until abandoned. Temporary absence from Iowa, with subsequent returns to Iowa, or intent to return when the purposes of the absence have been accomplished, does not interrupt continuity of residence.

41.23(2) *Suitability of home.* The home shall be deemed suitable until the court has ruled it unsuitable and, as a result of such action, the child has been removed from the home.

41.23(3) *Absence from the home.*

a. An individual who is absent from the home shall not be included in the assistance unit, except as described in paragraph "b."

(1) A parent who is a convicted offender but is permitted to live at home while serving a court-imposed sentence by performing unpaid public work or unpaid community service during the workday is considered absent from the home.

(2) A parent whose absence from the home is due solely to a pattern of employment is not considered to be absent.

(3) A parent whose absence is occasioned solely by reason of the performance of active duty in the uniformed services of the United States is considered absent from the home, notwithstanding the provisions of subrule 41.22(5). "Uniformed service" means the Army, Navy, Air Force, Marine Corps,

Coast Guard, National Oceanographic and Atmospheric Administration, or Public Health Service of the United States.

b. The needs of an individual who is temporarily out of the home are included in the eligible group, if otherwise eligible. A temporary absence exists in the following circumstances:

(1) An individual is anticipated to be in the medical institution for less than a year, as verified by a physician's statement. Failure to return within one year will result in the individual's needs being removed from the grant.

(2) An individual is out of the home to secure education or training, as defined for children in 41.24(2)"e" and for adults in rule 441—93.8(239B), first sentence, as long as the caretaker relative retains supervision of the child.

(3) An individual is out of the home for reasons other than reasons in subparagraphs (1) and (2) and the payee intends that the individual will return to the home within three months. Failure to return within three months will result in the individual's needs being removed from the grant.

41.23(4) *Battered aliens.* A person who meets the conditions of eligibility under Iowa Code section 239B.2 and who meets either of the following requirements shall be eligible for participation in the family investment program:

a. The person is a conditional resident alien who was battered or subjected to extreme cruelty, or whose child was battered or subjected to extreme cruelty, perpetrated by the person's spouse who is a United States citizen or lawful permanent resident, as described in 8 CFR Section 216.5(a)(3).

b. The person was battered or subjected to extreme cruelty, or the person's child was battered or subjected to extreme cruelty, perpetrated by the person's spouse who is a United States citizen or lawful permanent resident, and the person's petition has been approved or a petition is pending that sets forth a prima facie case that the person has noncitizen status under any of the following categories:

(1) Status as a spouse or child of a United States citizen or lawful permanent resident under the federal Immigration and Nationality Act, Section 204(a)(1)(A).

(2) Status as a spouse or child who was battered or subjected to extreme cruelty by a United States citizen or lawful permanent resident under the federal Immigration and Nationality Act, Section 204(a)(iii), as codified in 8 United States Code Section 1154(a)(1)(A)(iii).

(3) Classification as a person lawfully admitted for permanent residence under the federal Immigration and Nationality Act.

(4) Suspension of deportation and adjustment of status under the federal Immigration and Nationality Act, Section 244(a), as in effect before the date of enactment of the federal Illegal Immigration Reform and Immigrant Responsibility Act of 1996.

(5) Cancellation of removal or adjustment of status under the federal Immigration and Nationality Act, Section 240A, as codified in 8 United States Code Section 1229b.

(6) Status as an asylee, if asylum is pending, under the federal Immigration and Nationality Act, Section 208, as codified in 8 United States Code Section 1158.

41.23(5) *Citizenship and alienage.*

a. Eligible status. A family investment program assistance grant may include the needs of a citizen or national of the United States or a qualified alien as defined at rule 441—40.21(239B).

(1) A person who is a qualified alien as defined at rule 441—40.21(239B) is not eligible for family investment program assistance for a five-year period beginning on the date of the person's entry into the United States with a qualified alien status.

(2) EXCEPTIONS: The five-year prohibition from family investment program assistance does not apply to:

1. A qualified alien residing in the United States before August 22, 1996.

2. A battered alien as described at subrule 41.23(4).

3. A qualified alien veteran who has an honorable discharge that is not due to alienage.

4. A qualified alien who is on active duty in the Armed Forces of the United States other than active duty for training.

5. A qualified alien who is the spouse or unmarried dependent child of a qualified alien described in numbered paragraph "3" or "4," including a surviving spouse who has not remarried.

6. A refugee admitted under Section 207 of the Immigration and Nationality Act (INA).
7. An alien granted asylum under Section 208 of the INA.
8. An alien admitted as an Amerasian as described in 8 U.S.C. Section 1612(a)(2)(A)(ii)(V).
9. A Cuban/Haitian entrant as described in 8 U.S.C. Section 1641(b)(7).
10. An alien whose deportation is withheld under Section 243(h) or Section 241(b)(3) of the INA.
11. An alien certified as a victim of trafficking as described in Section 107(b)(1)(A) of Public Law 106-386 as amended to December 20, 2010.
12. An Iraqi or Afghan immigrant treated as a refugee pursuant to Section 1244(g) of Public Law 110-181 as amended to December 20, 2010, or to Section 602(b)(8) of Public Law 111-8 as amended to December 20, 2010.

b. Attestation of status. As a condition of eligibility, an attestation of citizenship or alien status shall be made for all applicants and recipients on Form 470-0462 or 470-0462(S), Financial Support Application, or Form 470-2549, Statement of Citizenship Status. Form 470-2881, 470-2881(S), 470-2881(M), or 470-2881(MS), Review/Recertification Eligibility Document, may be used to attest to the citizenship of dependent children who enter a recipient household. Failure to sign a form attesting to citizenship when required to do so creates ineligibility for the entire eligible group. The attestation may be signed by:

- (1) The applicant;
- (2) Someone acting responsibly on the applicant's or recipient's behalf if the applicant or recipient is incompetent or incapacitated; or
- (3) Any adult member of the assistance unit, when eligibility is determined on a family or household basis.

This rule is intended to implement Iowa Code sections 239B.2 and 239B.2B.
 [ARC 9439B, IAB 4/6/11, effective 6/1/11; ARC 1478C, IAB 6/11/14, effective 8/1/14]

441—41.24(239B) Promoting independence and self-sufficiency through employment job opportunities and basic skills (PROMISE JOBS) program. All persons in a family investment program (FIP) household shall be referred to the PROMISE JOBS program and shall enter into a family investment agreement (FIA) as a condition of receiving FIP, unless exempt from referral, except as described at subrule 41.24(2).

41.24(1) FIA-responsible persons. The following persons are FIA-responsible unless the department determines the person is exempt:

- a.* All persons whose needs are included in a grant under the FIP program.
- b.* Any parent living in the home of a child receiving a grant.
- c.* All FIP applicants unless the department determines that the applicant is exempt or does not meet other FIP eligibility requirements.
- d.* Applicants who have chosen and are in an active limited benefit plan (LBP). FIA-responsible applicants in an active limited benefit plan shall complete significant contact with or action in regard to PROMISE JOBS as described at paragraphs 41.24(8) "d" and "e" for FIP eligibility to be considered. For two-parent households, both parents must participate as previously stated except when one parent is exempt. Exceptions:

- (1) The applicant has become exempt from PROMISE JOBS.
- (2) The applicant is in a subsequent limited benefit plan and it is prior to the last day of the six-month period of ineligibility.

41.24(2) Exemptions. The following persons are exempt from referral:

- a.* and *b.* Rescinded IAB 12/3/97, effective 2/1/98.
- c.* A person who is under the age of 16 and is not a parent.
- d.* A person found eligible for supplemental security income (SSI) benefits based on disability or blindness.
- e.* A person who is aged 16 to 19, is not a parent, and attends an elementary, secondary or equivalent level of vocational or technical school full-time. For persons who lose exempt status for not

attending school, once the person has signed a family investment agreement, the person shall remain referred to PROMISE JOBS and subject to the terms of the agreement.

(1) A person shall be considered to be attending school full-time when enrolled or accepted in an elementary school, a secondary school, or the equivalent level of vocational or technical school or training leading to a certificate or diploma, and the school certifies the person's attendance as full-time. Enrollment in a correspondence school that gives instruction courses by mail is not an allowable program of study.

(2) A person shall also be considered to be in regular attendance in months when the person is not attending because of an official school or training program vacation, an illness, a convalescence, or a family emergency.

(3) A child meets the definition of regular school attendance until the child has been officially dropped from the school rolls.

f. A person who is not a United States citizen and is not a qualified alien as defined in rule 441—40.21(239B).

41.24(3) *Parents aged 19 and under.*

a. Unless exempt as described at subrule 41.24(2), parents aged 18 or 19 are referred to PROMISE JOBS as follows:

(1) A parent aged 18 or 19 who has not successfully completed a high school education (or its equivalent) shall be required to participate in educational activities, directed toward the attainment of a high school diploma or its equivalent.

(2) The parent shall be required to participate in other PROMISE JOBS options if the person fails to make good progress in completing educational activities or if it is determined that participation in educational activities is inappropriate for the parent.

(3) The parent shall be required to participate in parenting skills training in accordance with 441—Chapter 93.

b. Unless exempt as described at subrule 41.24(2), parents aged 17 or younger are referred to PROMISE JOBS as follows:

(1) A parent aged 17 or younger who has not successfully completed a high school education or its equivalent shall be required to participate in high school completion activities, directed toward the attainment of a high school diploma or its equivalent.

(2) The parent shall be required to participate in parenting skills training in accordance with 441—Chapter 93.

41.24(4) *Method of referral.* The department shall refer each FIA-responsible person as defined at subrule 41.24(1) to PROMISE JOBS to sign a family investment agreement.

a. FIA-responsible applicants. During the application interview, the department shall notify the applicant of the requirement to sign a family investment agreement as a condition of FIP eligibility. The department shall refer the applicant by scheduling the applicant for an appointment with the PROMISE JOBS provider agency to develop the family investment agreement.

(1) The appointment shall be on the earliest available date but no later than ten calendar days from the date of referral unless the applicant requests an appointment on a day that is beyond ten calendar days. The PROMISE JOBS provider agency shall make sufficient appointment times available to allow the applicant to be scheduled within this time frame.

(2) The applicant shall be notified verbally and in writing of the scheduled appointment. If the notice of a scheduled appointment is mailed to the applicant, the department shall allow at least five working days from the date the notice is mailed for the applicant to appear for the scheduled appointment. The department may allow less than five working days if the applicant is verbally notified and agrees to the appointment.

(3) If a parent fails to appear for an appointment without rescheduling or fails to sign a family investment agreement, the department shall deny FIP assistance for the entire family.

(4) If a minor parent fails to appear for an appointment without rescheduling or fails to sign a family investment agreement, the department shall deny FIP assistance for the minor parent and any child of the minor parent.

(5) If a referred person who is not a parent fails to appear for an appointment without rescheduling or fails to sign a family investment agreement, the department shall deny FIP assistance only for that person.

b. Hardship applicants. While the eligibility decision is pending, the department shall refer applicants who must qualify for a hardship exemption before approval of FIP to PROMISE JOBS to sign a family investment agreement as described in paragraph 41.24(4)“a” and shall treat applicants in accordance with subrule 41.30(3).

c. Applicants in a limited benefit plan. The department shall refer FIA-responsible applicants to PROMISE JOBS as described in paragraph 41.24(4)“a” and inform the applicant of the actions needed to reconsider and end the limited benefit plan as described at subrule 41.24(8). Failure to appear for the appointment without rescheduling or failure to sign a family investment agreement results in denial of the FIP application.

d. FIP participants who become FIA-responsible. When a person receiving FIP is no longer exempt, the department shall send the FIP participant a notice. The notice shall contain information about the requirement to sign a family investment agreement and shall instruct the FIP participant to contact PROMISE JOBS within ten calendar days to schedule an appointment with PROMISE JOBS to develop a family investment agreement. If the participant fails to schedule or attend the appointment or fails to sign a family investment agreement, PROMISE JOBS will send a clear written reminder. After one written reminder as described at 441—paragraph 93.3(3)“b,” the participant shall enter into a limited benefit plan as described at paragraph 41.24(8)“c.”

41.24(5) Changes in status and redetermination of exempt status. Any exempt person shall report any change affecting the exempt status to the department within ten days of the change. The department shall reevaluate exempt persons when changes in status occur and at the time of six-month or annual review. The participant and the PROMISE JOBS unit shall be notified of any change in a participant’s exempt status.

41.24(6) Volunteers. Rescinded IAB 7/21/04, effective 9/1/04.

41.24(7) Referral to vocational rehabilitation. The department shall make the department of education, division of vocational rehabilitation services, aware of any person who is referred to PROMISE JOBS and who has a medically determined physical or mental disability and a substantial employment limitation resulting from the disability. However, acceptance of vocational rehabilitation services by the client is optional.

41.24(8) The limited benefit plan (LBP). When a participant responsible for signing and meeting the terms of a family investment agreement as described at rule 441—93.4(239B) chooses not to sign or fulfill the terms of the agreement, the FIP assistance unit or the individual participant shall enter into a limited benefit plan. A limited benefit plan is considered imposed as of the date that a timely and adequate notice is issued to the participant as defined at 441—subrule 7.7(1). Once the limited benefit plan is imposed, FIP eligibility no longer exists as of the first of the month after the month in which timely and adequate notice is given to the participant. Upon the issuance of the notice to impose a limited benefit plan, the person who chose the limited benefit plan can reconsider and end the limited benefit plan, but only as described at paragraphs 41.24(8)“d” and “e.”

a. A limited benefit plan shall either be a first limited benefit plan or a subsequent limited benefit plan. From the effective date of a first limited benefit plan, the FIP eligible group or individual participant shall not be eligible until the participant who chose the limited benefit plan completes significant contact with or action in regard to the PROMISE JOBS program as defined in paragraph 41.24(8)“d.” If a subsequent limited benefit plan is chosen by the same participant, a six-month period of ineligibility applies to the FIP eligible group or individual participant and ineligibility continues after the six-month period is over until the participant who chose the limited benefit plan completes significant contact with or action in regard to the PROMISE JOBS program as defined in paragraph 41.24(8)“e.” A limited benefit plan imposed in error as described in paragraph 41.24(8)“g” shall not be considered a limited benefit plan and shall not count when determining whether a household is subject to a subsequent limited benefit plan.

b. The limited benefit plan shall be applied to participants responsible for the family investment agreement and other members of the participant's family as follows:

(1) When the participant responsible for the family investment agreement is a parent, the limited benefit plan shall apply to the entire FIP eligible group as defined at subrule 41.28(1).

(2) When the participant choosing a limited benefit plan is a needy specified relative or a dependent child's stepparent who is in the FIP eligible group because of incapacity, the limited benefit plan shall apply only to the individual participant choosing the plan. EXCEPTION: The limited benefit plan shall apply to the entire FIP eligible group as defined at subrule 41.28(1) when a needy specified relative who assumes the role of parent was responsible for the family investment agreement and chose a limited benefit plan effective October 1, 2005, or earlier.

(3) When the FIP eligible group includes a minor parent living with the minor parent's adult parent or needy specified relative who receives FIP benefits and both the minor parent and the adult parent or needy specified relative are responsible for developing a family investment agreement, each parent or needy specified relative is responsible for a separate family investment agreement, and the limited benefit plan shall be applied as follows:

1. When the adult parent chooses the limited benefit plan, the requirements of the limited benefit plan shall apply to the entire eligible group, even though the minor parent has not chosen the limited benefit plan. However, the minor parent may reapply for FIP benefits as a minor parent living with self-supporting parents or as a minor parent living independently and continue in the family investment agreement process.

2. When the minor parent chooses the limited benefit plan, the requirements of the limited benefit plan shall apply to the minor parent and any child of the minor parent.

3. When the minor parent is the only eligible child in the adult parent's or needy specified relative's home and the minor parent chooses the limited benefit plan, the adult parent's or needy specified relative's FIP eligibility ceases in accordance with subrule 41.28(1). The adult parent or needy specified relative shall become ineligible beginning with the effective date of the minor parent's limited benefit plan.

4. When the needy specified relative chooses the limited benefit plan, the requirements of the limited benefit plan shall apply as described at subparagraph 41.24(8) "b"(2).

(4) When the FIP eligible group includes children who are FIA-responsible, the children shall not have a separate family investment agreement but shall be asked to sign the eligible group's family investment agreement and to carry out the responsibilities of that family investment agreement. A limited benefit plan shall be applied as follows:

1. When the parent or needy specified relative responsible for a family investment agreement meets those responsibilities but a child who is FIA-responsible chooses an individual limited benefit plan, the limited benefit plan shall apply only to the individual child choosing the plan.

2. When the child who chooses a limited benefit plan under numbered paragraph 41.24(8) "b"(4) "1" is the only child in the eligible group, the parents' or needy specified relative's eligibility ceases in accordance with subrule 41.28(1). The parents or needy specified relative shall become ineligible beginning with the effective date of the child's limited benefit plan.

(5) When the FIP eligible group includes parents or needy specified relatives who are exempt from PROMISE JOBS participation and children who are FIA-responsible, the children are responsible for completing a family investment agreement. If a child who is FIA-responsible chooses the limited benefit plan, the limited benefit plan shall be applied in the manner described in subparagraph 41.24(8) "b"(4).

(6) When both parents of a FIP child are in the home, a limited benefit plan shall be applied as follows:

1. When only one parent of a child in the eligible group is responsible for a family investment agreement and that parent chooses the limited benefit plan, the limited benefit plan applies to the entire family and cannot be ended by the voluntary participation in a family investment agreement by the exempt parent.

2. When both parents of a child in the eligible group are responsible for a family investment agreement, both are expected to sign the agreement. If either parent chooses the limited benefit plan,

the limited benefit plan cannot be ended by the participation of the other parent in a family investment agreement.

3. When the parents from a two-parent family in a limited benefit plan separate, the limited benefit plan shall follow only the parent who chose the limited benefit plan and any children in the home of that parent.

4. A subsequent limited benefit plan applies when either parent in a two-parent family previously chose a limited benefit plan.

c. A participant shall be considered to have chosen a limited benefit plan under any of the following circumstances:

(1) A participant who loses exempt status and is referred to PROMISE JOBS as described at paragraph 41.24(4)“d” and who does not schedule or attend an appointment for orientation and development of a family investment agreement with PROMISE JOBS after PROMISE JOBS sends one clear written reminder as described at 441—paragraph 93.3(3)“b” shall enter into the limited benefit plan.

(2) A participant who chooses not to sign the family investment agreement shall enter into the limited benefit plan. For an applicant, signing a family investment agreement is a FIP eligibility requirement. If an applicant chooses not to sign the agreement, the limited benefit plan process is not applicable.

(3) A participant who signs a family investment agreement but does not carry out the family investment agreement responsibilities shall enter into a limited benefit plan whether the person signed the agreement as a FIP applicant or as a FIP participant. This includes a participant who fails to respond to the PROMISE JOBS worker’s request to renegotiate the family investment agreement when the participant has not attained self-sufficiency by the date established in the family investment agreement. A limited benefit plan shall be imposed regardless of whether the request to renegotiate is made before or after expiration of the family investment agreement.

d. Reconsideration of a first limited benefit plan. A person who chooses a first limited benefit plan may reconsider at any time from the date timely and adequate notice is issued establishing the limited benefit plan. To reconsider and end the limited benefit plan, the person must communicate the desire to engage in PROMISE JOBS activities to the department or appropriate PROMISE JOBS office and develop and sign the family investment agreement.

(1) Since a first limited benefit plan is considered imposed as of the date that a timely and adequate notice is issued, the person who chose the limited benefit plan cannot end it by complying with the issue that resulted in its imposition. To end the limited benefit plan, the person must also sign a family investment agreement, even if the person had signed an agreement before choosing the limited benefit plan.

(2) FIP benefits shall be effective the date the family investment agreement is signed or the effective date of the grant as described in rule 441—40.26(239B), whichever date is later. FIP benefits may be reinstated in accordance with 441—subrule 40.22(5) when the family investment agreement is signed before the effective date of a first limited benefit plan.

e. Reconsideration of a subsequent limited benefit plan. A person who chooses a subsequent limited benefit plan may reconsider that choice at any time following the required six-month period of ineligibility.

(1) A subsequent limited benefit plan is considered imposed as of the date that a timely and adequate notice is issued to establish the limited benefit plan. Therefore, once timely and adequate notice is issued, the person who chose the limited benefit plan cannot end it by complying with the issue that resulted in its imposition.

(2) FIP eligibility no longer exists as of the effective date of the limited benefit plan. Eligibility cannot be reestablished until the six-month period of ineligibility has expired. FIP eligibility does not exist for a person who reapplies for FIP after the notice is issued and before the effective date of the limited benefit plan because the person is not eligible to sign a family investment agreement until the six-month period of ineligibility has expired.

(3) To reconsider and end the limited benefit plan, the person must:

1. Contact the department or the appropriate PROMISE JOBS office to communicate the desire to engage in PROMISE JOBS activities,

2. Sign a new or updated family investment agreement, and

3. Satisfactorily complete 20 hours of employment or the equivalent in an activity other than work experience or unpaid community service, unless problems as described at rule 441—93.14(239B) or barriers as described at 441—subrule 93.4(5) apply. The 20 hours of employment or other activity must be completed within 30 days of the date that the family investment agreement is signed, unless problems as described at rule 441—93.14(239B) or barriers as described at 441—subrule 93.4(5) apply.

- (4) FIP benefits shall not begin until the person who chose the limited benefit plan completes the previously defined significant actions. FIP benefits shall be effective the date the family investment agreement is signed or the effective date of the grant as described in rule 441—40.26(239B), whichever date is later, but in no case shall the effective date be within the six-month period of ineligibility.

- f. Reconsideration by two-parent family. For a two-parent family when both parents are responsible for a family investment agreement as described at subrule 41.24(1), a first or subsequent limited benefit plan continues until both parents have completed significant contact or action with the PROMISE JOBS program as described in paragraphs “d” and “e” above.

- g. Limited benefit plan imposed in error. A limited benefit plan imposed in error shall not be considered a limited benefit plan. This includes any instance when participation in PROMISE JOBS should not have been required as described in the administrative rules. Examples of instances when an error has occurred are:

- (1) The person was exempt from PROMISE JOBS participation at the time the person chose the limited benefit plan.

- (2) It is verified that the person considered to have chosen the limited benefit plan moved out of state or requested cancellation of FIP prior to the date that PROMISE JOBS determined the limited benefit plan was chosen.

- (3) The final appeal decision under 441—Chapter 7 reverses the decision to impose a limited benefit plan.

- (4) It is determined that the entire amount of assistance issued for the person who chose the limited benefit plan is subject to recoupment for the month when the person chose not to fulfill the terms of the family investment agreement.

- (5) The person informs PROMISE JOBS of a newly revealed problem as described at rule 441—93.14(239B) or barrier as described at 441—subrule 93.4(5) after the limited benefit plan is imposed, and it is reasonable that the problem or barrier contributed to a failure that resulted in imposition of the limited benefit plan. The person may be required to provide documentation of the problem or barrier as described at 441—subrule 93.10(3).

41.24(9) *Nonparticipation by volunteer participants.* Rescinded IAB 7/21/04, effective 9/1/04.

41.24(10) *Notification of services.*

- a. The department shall inform all applicants for and recipients of FIP of the advantages of employment under FIP.

- b. The department shall provide a full explanation of the family rights, responsibilities, and obligations under PROMISE JOBS and the FIA, with information on the time-limited nature of the agreement.

- c. The department shall provide information on the employment, education and training opportunities, and support services to which they are entitled under PROMISE JOBS, as well as the obligations of the department. This information shall include explanations of child care assistance and transitional Medicaid.

- d. The department shall inform applicants for and recipients of FIP benefits of the grounds for exemption from FIA responsibility and from participation in the PROMISE JOBS program.

- e. The department shall explain the LBP and the process by which FIA-responsible persons can choose the LBP.

- f. The department shall inform all applicants for and recipients of FIP of their responsibility to cooperate in establishing paternity and enforcing child support obligations.

g. The department shall inform applicants for FIP benefits that a family investment agreement must be signed before FIP approval as a condition of eligibility, except as described at subrule 41.24(2). [ARC 9439B, IAB 4/6/11, effective 6/1/11; ARC 1146C, IAB 10/30/13, effective 1/1/14; ARC 1208C, IAB 12/11/13, effective 2/1/14]

441—41.25(239B) Uncategorized factors of eligibility.

41.25(1) *Divesting of income.* Assistance shall not be approved when an investigation proves that income was divested and the action was deliberate and for the primary purpose of qualifying for assistance or increasing the amount of assistance paid.

41.25(2) *Duplication of assistance.* A recipient whose needs are included in a family investment program grant shall not concurrently receive a grant under any other public assistance program administered by the department, including IV-E foster care or state-funded foster care.

a. A recipient shall not concurrently receive the family investment program and subsidized adoption unless exclusion of the person from the FIP grant will reduce benefits to the family.

b. When a family investment program recipient is approved for foster care or subsidized adoption assistance while remaining in the same home, family investment program assistance shall be canceled effective the first day of the next calendar month following the date approval of the foster care or subsidized adoption payment is successfully entered into the department's computer system. FIP assistance for the month for which the foster care or subsidized adoption payment is approved or any past months for which foster care or subsidized adoption payments are made retroactively shall not be subject to recoupment.

c. A recipient shall not concurrently receive a grant from a public assistance program in another state.

d. When a recipient leaves the home of a specified relative, no payment for a concurrent period shall be made for the same recipient in the home of another relative.

41.25(3) *Aid from other funds.* Supplemental aid from any other agency or organization shall be limited to aid for items of need not covered by the department's standards and to the amount of the percentage reduction used in determining the payment level. Any duplicated assistance shall be considered unearned income.

41.25(4) *Contracts for support.* A person entitled to total support under the terms of an enforceable contract is not eligible to receive the family investment program when the other party, obligated to provide the support, is able to fulfill that part of the contract.

41.25(5) *Participation in a strike.*

a. The family of any parent with whom the child(ren) is living shall be ineligible for the family investment program for any month in which the parent is participating in a strike on the last day of the month.

b. Any individual shall be ineligible for the family investment program for any month in which the individual is participating in a strike on the last day of that month.

c. Definitions:

(1) A strike is a concerted stoppage of work by employees (including a stoppage by reason of expiration of a collective bargaining agreement) and any concerted slowdown or other concerted interruption of operations by employees.

(2) An individual is not participating in a strike at the individual's place of employment when the individual is not picketing and does not intend to picket during the course of the dispute, does not draw strike pay, and provides a signed statement that the individual is willing and ready to return to work but does not want to cross the picket line solely because of the risk of personal injury or death or trauma from harassment. The district administrator shall determine whether such a risk to the individual's physical or emotional well-being exists.

41.25(6) *Graduate students.* The entire assistance unit is ineligible for FIP when a member of the assistance unit is enrolled in an educational program leading to a degree beyond a bachelor's degree.

41.25(7) *Time limit for receiving assistance.* Rescinded IAB 7/11/01, effective 9/1/01.

41.25(8) *School attendance requirements.* Rescinded IAB 7/7/04, effective 7/1/04.

41.25(9) *Pilot diversion programs.* Assistance shall not be approved when an assistance unit is subject to a period of ineligibility as described at 441—Chapter 47.

41.25(10) *Fugitive felons, and probation and parole violators.* Assistance shall be denied to a person who is (1) convicted of a felony under state or federal law and is fleeing to avoid prosecution, custody or confinement, or (2) violating a condition of probation or parole imposed under state or federal law. The prohibition does not apply to conduct pardoned by the President of the United States, beginning with the month after the pardon is given.

41.25(11) *Access to benefits.*

a. A recipient shall not use the recipient's electronic access card issued pursuant to 441—subrule 45.21(1) to access benefits at any of the following prohibited locations as defined by federal statute or regulation applicable to this prohibition:

- (1) A liquor store,
- (2) A casino, gambling casino or gaming establishment, or
- (3) A retail establishment that provides adult-oriented entertainment in which performers disrobe or perform in an unclothed state for entertainment.

b. When the department receives a detailed complaint or suspects that a recipient has used the recipient's electronic access card at a prohibited location, the case shall be referred to the department of inspections and appeals for further investigation.

c. When the department of inspections and appeals finds that a recipient has used the recipient's electronic access card at a prohibited location, the household that includes the recipient is:

- (1) Considered to have committed a fraudulent act;
- (2) Liable for any amounts accessed at a prohibited location and required to repay such amount in accordance with 441—Chapter 46;
- (3) Ineligible for FIP for a three-month period after the first report by the department of inspections and appeals which includes a finding of misuse;
- (4) Ineligible for FIP for a six-month period after each subsequent report by the department of inspections and appeals which includes a finding of misuse.

d. When parents from a two-parent family separate during an ineligibility period, if:

- (1) The department of inspections and appeals investigation identifies the recipient who used the electronic access card at a prohibited location, the ineligibility period will follow that recipient.
- (2) The department of inspections and appeals investigation does not identify the recipient who used the electronic access card at a prohibited location, the ineligibility period will follow the recipient who is the case name when the violation occurred.

e. A new period of ineligibility shall be established when:

- (1) A recipient files an appeal either:
 1. Before the effective date of the intended action on the notice of decision or notice of action establishing the beginning date of the ineligibility period, or
 2. Within ten days from the date on which a notice establishing the beginning date of the ineligibility period is received. The date on which notice is received is considered to be five days after the date on the notice, unless the beneficiary shows that the beneficiary did not receive the notice within the five-day period;
- (2) Assistance is continued pending the final decision of the appeal; and
- (3) The department's action is affirmed.

Assistance issued pending the final decision of an appeal is not subject to recovery pursuant to 441—subrule 7.9(6).

This rule is intended to implement Iowa Code chapter 239B.

[ARC 1207C, IAB 12/11/13, effective 2/1/14; ARC 1478C, IAB 6/11/14, effective 8/1/14; ARC 1694C, IAB 10/29/14, effective 1/1/15]

441—41.26(239B) Resources.

41.26(1) Limitation. An applicant or recipient may have the following resources and be eligible for the family investment program. Any resource not specifically exempted shall be counted toward resource limitations.

a. A homestead without regard to its value. A mobile home or similar shelter shall be considered as a homestead when it is occupied by the recipient. Temporary absence from the homestead with a defined purpose for the absence and with intent to return when the purpose of the absence has been accomplished shall not be considered to have altered the exempt status of the homestead. Except as described at 41.26(1) “*n*” or “*o*” and 41.26(6) “*d*,” the net market value of any other real property shall be considered with personal property.

b. Household goods and personal effects without regard to their value. Personal effects are personal or intimate tangible belongings of an individual, especially those that are worn or carried on the person, which are maintained in one’s home, and include clothing, books, grooming aids, jewelry, hobby equipment, and similar items.

c. Life insurance which has no cash surrender value. The owner of the life insurance policy is the individual paying the premium on the policy with the right to change the policy as the individual sees fit.

d. Motor vehicles.

(1) One motor vehicle without regard to its value.

(2) An equity not to exceed a value of \$4115 in one motor vehicle for each adult and working teenage child whose resources must be considered as described in 41.26(2). The disregard shall be allowed when the working teenager is temporarily absent from work. The equity value in excess of \$4115 of any vehicle shall be counted toward the resource limit in 41.26(1) “*e*.” When a motor vehicle is modified with special equipment for the handicapped, the special equipment shall not increase the value of the motor vehicle.

The department shall annually increase the motor vehicle equity value to be disregarded by the latest increase in the consumer price index for used vehicles during the previous state fiscal year.

e. A reserve of other property, real or personal, not to exceed \$2000 for applicant assistance units and \$5000 for recipient assistance units. EXCEPTION: Applicant assistance units with at least one member who was a recipient in Iowa in the month prior to the month of application are subject to the \$5000 limit. The exception includes those persons who did not receive an assistance grant due to the limitations described at rules 441—45.26(239B) and 45.27(239B) and persons whose grants were suspended as in 41.27(9) “*f*” in the month prior to the month of application.

Resources of the applicant or the recipient shall be determined in accordance with subrule 41.26(2).

f. Money which is counted as income in a month, during that same month; and that part of lump sum income defined in 41.27(9) “*c*”(2) reserved for the current or future month’s income.

g. Payments which are exempted for consideration as income and resources under subrule 41.27(6).

h. An equity not to exceed \$1,500 in one funeral contract or burial trust for each member of the eligible group. Any amount in excess of \$1,500 shall be counted toward resource limitations unless it is established that the funeral contract or burial trust is irrevocable.

i. One burial plot for each member of the eligible group. A burial plot is defined as a conventional gravesite, crypt, mausoleum, urn, or other repository which is customarily and traditionally used for the remains of a deceased person.

j. Settlements for payment of medical expenses.

k. Life estates.

l. Federal or state earned income tax credit payments in the month of receipt and the following month, regardless of whether these payments are received with the regular paychecks or as a lump sum with the federal or state income tax refund.

m. The balance in an individual development account (IDA), including interest earned on the IDA.

n. An equity not to exceed \$10,000 for tools of the trade or capital assets of self-employed households.

When the value of any resource is exempted in part, that portion of the value which exceeds the exemption shall be considered in computing whether the eligible group's property is within the reserve defined in paragraph "e."

o. Nonhomestead property that produces income consistent with the property's fair market value.

41.26(2) *Persons considered.*

a. Resources of persons in the eligible group shall be considered in establishing property limitations.

b. Resources of the parent who is living in the home with the eligible child(ren) but whose needs are excluded from the eligible group shall be considered in the same manner as if the parent were included in the eligible group.

c. Resources of the stepparent living in the home shall not be considered when determining eligibility of the eligible group, with one exception: The resources of a stepparent included in the eligible group shall be considered in the same manner as a parent.

d. The resources of supplemental security income recipients shall not be counted in establishing property limitations.

e. The resources of a nonparental relative who elects to be included in the eligible group shall be considered in the same manner as a parent.

f. and *g.* Rescinded IAB 10/4/00, effective 12/1/00.

41.26(3) *Homestead defined.* The homestead consists of the house, used as a home, and may contain one or more contiguous lots or tracts of land, including buildings and appurtenances. When within a city plat, it shall not exceed ½-acre in area. When outside a city plat it shall not contain, in the aggregate, more than 40 acres. When property used as a home exceeds these limitations, the equity value of the excess property shall be determined in accordance with subrule 41.26(5).

41.26(4) *Liquidation.* When proceeds from the sale of resources or conversion of a resource to cash, together with other nonexempted resources, exceed the property limitations, the recipient is ineligible to receive assistance until the amount in excess of the resource limitation has been expended unless immediately used to purchase a homestead, or reduce the mortgage on a homestead.

a. Property settlements. Property settlements which are part of a legal action in a dissolution of marriage or palimony suit are considered as resources upon receipt.

b. Property sold under installment contract. Property sold under an installment contract or held as security in exchange for a price consistent with its fair market value is exempt as a resource. If the price is not consistent with the contract's fair market value, the resource value of the installment contract is the gross price for which it can be sold or discounted on the open market, less any legal debts, claims, or liens against the installment contract.

Payments from property sold under an installment contract are exempt as income as specified in paragraphs 41.27(1) "*f*" and 41.27(7) "*ah*." The portion of any payment received representing principal is considered a resource upon receipt. The interest portion of the payment is considered a resource the month following the month of receipt.

41.26(5) *Net market value defined.* Net market value is the gross price for which property or an item can currently be sold on the open market, less any legal debts, claims, or liens against the property or item.

41.26(6) *Availability.*

a. A resource must be available in order for it to be counted toward resource limitations. A resource is considered available under the following circumstances:

(1) The applicant/recipient owns the property in part or in full and has control over it; that is, it can be occupied, rented, leased, sold, or otherwise used or disposed of at the individual's discretion.

(2) The applicant/recipient has a legal interest in a liquidated sum and has the legal ability to make the sum available for support and maintenance.

b. Rescinded IAB 6/30/99, effective 9/1/99.

c. When property is owned by more than one person, unless otherwise established, it is assumed that all individuals hold equal shares in the property.

d. When the applicant or recipient owns nonhomestead property, the property shall be considered exempt for so long as the property is publicly advertised for sale at an asking price that is consistent with its fair market value.

41.26(7) *Damage judgments and insurance settlements.*

a. Payment resulting from damage to or destruction of an exempt resource shall be considered a resource to the applicant/recipient the month following the month the payment was received. When the applicant/recipient signs a legal binding commitment no later than the month after the month the payment was received, the funds shall be considered exempt for the duration of the commitment providing the terms of the commitment are met within eight months from the date of commitment.

b. Payment resulting from damage to or destruction of a nonexempt resource shall be considered a resource in the month following the month in which payment was received.

41.26(8) *Trusts.* The department shall determine whether assets from a trust or conservatorship, except one established solely for the payment of medical expenses, are available by examining the language of the trust agreement or order establishing a conservatorship.

a. Funds clearly conserved and available for care, support, or maintenance shall be considered toward resource or income limitations.

b. When the department questions whether the funds in a trust or conservatorship are available, the trust or conservatorship shall be referred to the central office.

(1) When assets in the trust or conservatorship are not clearly available, central office staff may contact the trustee or conservator and request that the funds in the trust or conservatorship be made available for current support and maintenance. When the trustee or conservator chooses not to make the funds available, the department may petition the court to have the funds released either partially or in their entirety or as periodic income payments.

(2) Funds in a trust or conservatorship that are not clearly available shall be considered unavailable until the trustee, conservator or court actually makes the funds available. Payments received from the trust or conservatorship for basic or special needs are considered income.

41.26(9) *Aliens sponsored by individuals.* When an alien admitted for lawful permanent residence is sponsored by a person who executed an enforceable affidavit of support as described in 8 U.S.C. Section 1631(a)(1) on behalf of the alien, the resources of the alien shall be deemed to include the resources of the sponsor (and of the sponsor's spouse if living with the sponsor). The amount of the resources of the sponsor and the sponsor's spouse deemed to the alien shall be the total countable resources as described in rule 441—41.26(239B) remaining after a \$1,500 deduction is subtracted. The following are exceptions to deeming of a sponsor's resources:

a. Deeming of the sponsor's resources does not apply when:

(1) The sponsored alien attains citizenship through naturalization pursuant to Chapter 2 of Title III of the Immigration and Nationality Act;

(2) The sponsored alien has earned 40 qualifying quarters of coverage as defined in Title II of the Social Security Act or can be credited with 40 qualifying quarters as defined at rule 441—40.21(239B); or

(3) The sponsored alien or the sponsor dies.

b. An indigent alien is exempt from the deeming of a sponsor's resources for 12 months after indigence is determined. An alien shall be considered indigent if:

(1) The alien does not live with the sponsor; and

(2) The alien's gross income, including any income received from or made available by the sponsor, is less than 100 percent of the federal poverty level for the sponsored alien's household size.

c. A battered alien as described in 8 U.S.C. Section 1641(c) is exempt from the deeming of a sponsor's resources for 12 months.

41.26(10) *Not considered a resource.* Inventories and supplies, exclusive of capital assets, that are required for self-employment shall not be considered a resource. Inventory is defined as all unsold items, whether raised or purchased, that are held for sale or use and shall include, but not be limited to, merchandise, grain held in storage and livestock raised for sale. Supplies are items necessary for the operation of the enterprise, such as lumber, paint and seed. Capital assets are those assets which, if sold

at a later date, could be used to claim capital gains or losses for federal income tax purposes. When self-employment is temporarily interrupted due to circumstances beyond the control of the household, such as illness, and inventory or supplies retained by the household shall not be considered a resource.

This rule is intended to implement Iowa Code section 239B.5.

[ARC 9439B, IAB 4/6/11, effective 6/1/11]

441—41.27(239B) Income. All unearned and earned income, unless specifically exempted, disregarded, deducted for work expenses, or diverted as defined in these rules, shall be considered in determining initial and continuing eligibility and the amount of the family investment program grant.

1. The determination of initial eligibility is a three-step process. Initial eligibility shall be granted only when (1) the countable gross nonexempt unearned and earned income, exclusive of the family investment program grant, received by the eligible group and available to meet the current month's needs is no more than 185 percent of the standard of need for the eligible group; (2) the countable net unearned and earned income is less than the standard of need for the eligible group; and (3) the countable net unearned and earned income, after applying allowable disregards, is less than the payment standard for the eligible group.

2. The determination of continuing eligibility is a two-step process. Continuing eligibility shall be granted only when (1) countable gross nonexempt income, as described for initial eligibility, does not exceed 185 percent of the standard of need for the eligible group; and (2) countable net unearned and earned income is less than the payment standard for the eligible group.

3. The amount of the family investment program grant shall be determined by subtracting countable net income from the payment standard for the eligible group. Child support assigned to the department in accordance with subrule 41.22(7) and retained by the department as described in subparagraph 41.27(1)“h”(2) shall be considered as exempt income for the purpose of determining continuing eligibility, including child support as specified in paragraph 41.27(7)“q.” Deductions and diversions shall be allowed when verification is provided.

41.27(1) Unearned income. Unearned income is any income in cash that is not gained by labor or service. When taxes are withheld from unearned income, the amount considered will be the net income after the withholding of taxes (Federal Insurance Contribution Act, state and federal income taxes). Net unearned income shall be determined by deducting reasonable income-producing costs from the gross unearned income. Money left after this deduction shall be considered gross income available to meet the needs of the eligible group.

a. Social security income is the amount of the entitlement before withholding of a Medicare premium.

b. Rescinded, effective December 1, 1986.

c. Rescinded, effective September 1, 1980.

d. Rescinded IAB 2/11/98, effective 2/1/98.

e. Rescinded IAB 2/11/98, effective 2/1/98.

f. When the applicant or recipient sells property on contract, proceeds from the sale shall be considered exempt as income. The portion of any payment that represents principal is considered a resource upon receipt as defined in 41.26(4). The interest portion of the payment is considered a resource the month following the month of receipt.

g. Every person in the eligible group and any parent living in the home of a child in the eligible group shall take all steps necessary to apply for and, if entitled, accept any financial benefit for which that person may be qualified, even though the benefit may be reduced because of the laws governing a particular benefit. When the person claims a physical or mental disability that is expected to last continuously for 12 months from the time of the claim or to result in death and the person is unable to engage in substantial activity due to the disability, or the person otherwise appears eligible, as the person is aged 65 or older or is blind, the person shall apply for social security benefits and supplemental security income benefits.

(1) Except as described in subparagraph (2), the needs of any person who refuses to take all steps necessary to apply for and, if eligible, to accept other financial benefits shall be removed from the eligible group. The person remains eligible for the work incentive disregard described in paragraph 41.27(2) “c.”

(2) The entire assistance unit is ineligible for FIP when a person refuses to apply for or, if entitled, to accept social security or supplemental security income. For applicants, this subparagraph applies to those who apply on or after July 1, 2002. For FIP recipients, this subparagraph applies at the time of the next six-month or annual review as described at 441—subrule 40.27(1) or when the recipient reports a change that may qualify a person in the eligible group or a parent living in the home for these benefits, whichever occurs earlier.

h. Support payments in cash shall be considered as unearned income in determining initial and continuing eligibility.

(1) Any nonexempt cash support payment for a member of the eligible group, made while the application is pending, shall be treated as unearned income and deducted from the initial assistance grant(s). Any cash support payment for a member of the eligible group, except as described at 41.27(7) “p” and “q,” received by the recipient after the date of decision as defined in 441—subrule 40.24(4) shall be refunded to the child support recovery unit.

(2) Assigned support collected in a month and retained by child support recovery shall be exempt as income for determining prospective or retrospective eligibility. Participants shall have the option of withdrawing from FIP at any time and receiving their child support direct.

(3) and (4) Rescinded IAB 12/3/97, effective 2/1/98.

i. The applicant or recipient shall cooperate in supplying verification of all unearned income, as defined at rule 441—40.21(239B). When the information is available, the department shall verify job insurance benefits by using information supplied to the department by the department of workforce development. When the department uses this information as verification, job insurance benefits shall be considered received the second day after the date that the check was mailed by workforce development. When the second day falls on a Sunday or federal legal holiday, the time shall be extended to the next mail delivery day. When the client notifies the department that the amount of job insurance benefits used is incorrect, the client shall be allowed to verify the discrepancy. A payment adjustment shall be made when indicated. Recoupment shall be made for any overpayment. The client must report the discrepancy prior to the payment month or within ten days of the date on the Notice of Decision, Form 470-0485(C) or 470-0486(M), applicable to the payment month, whichever is later, in order to receive a payment adjustment.

41.27(2) Earned income. Earned income is defined as income in the form of a salary, wages, tips, bonuses, commissions earned as an employee, income from Job Corps, or profit from self-employment. Earned income from commissions, wages, tips, bonuses, Job Corps, or salary means the total gross amount irrespective of the expenses of employment. Income shall be considered earned income when it is produced as a result of the performance of services by an individual.

a. Earned income deduction. Each person in the assistance unit whose gross nonexempt earned income, earned as an employee or net profit from self-employment, is considered in determining eligibility and the amount of the assistance grant is entitled to one 20 percent earned income deduction of nonexempt monthly gross earnings. The deduction is intended to include all work-related expenses other than child care. These expenses shall include, but not be limited to, all of the following: taxes, transportation, meals, uniforms, and other work-related expenses.

b. Rescinded IAB 12/29/99, effective 3/1/00.

c. Work incentive disregard. After deducting the allowable work-related expenses as defined in paragraph 41.27(2) “a” and income diversions as defined in subrules 41.27(4) and 41.27(8), the department shall disregard 58 percent of the total of the remaining monthly nonexempt earned income, earned as an employee or the net profit from self-employment, of each person whose income must be considered in determining eligibility and the amount of the assistance grant.

(1) The work incentive disregard is not time-limited.

(2) Initial eligibility is determined without the application of the work incentive disregard as described at subparagraphs 41.27(9) “a”(2) and (3).

d. Self-employment. A person is considered self-employed when the person:

- (1) Is not required to report to the office regularly except for specific purposes such as sales training meetings, administrative meetings, or evaluation sessions.
- (2) Establishes the person's own working hours, territory, and methods of work.
- (3) Files quarterly reports of earnings, withholding payments, and FICA payments to the Internal Revenue Service.

e. Self-employment income. Earned income from self-employment as defined in paragraph 41.27(2) "d" means the net profit from self-employment. "Net profit" means gross self-employment income less:

- (1) Forty percent of the gross income to cover the costs of producing the income, or
- (2) At the request of the applicant or recipient, actual expenses determined in the manner specified in paragraph 41.27(2) "f."

f. Deduction of self-employment expenses. When the applicant or recipient requests that actual expenses be deducted, the net profit from self-employment income shall be determined by deducting only the following expenses that are directly related to the production of the income:

- (1) The cost of inventories and supplies purchased that are required for the business, such as items for sale or consumption and raw materials.
- (2) Wages, commissions, and mandated costs relating to the wages for employees of the self-employed.
- (3) The cost of shelter in the form of rent; the interest on mortgage or contract payments; taxes; and utilities.
- (4) The cost of machinery and equipment in the form of rent or the interest on mortgage or contract payments.
- (5) Insurance on the real or personal property involved.
- (6) The cost of any repairs needed.
- (7) The cost of any travel required.
- (8) Any other expense directly related to the production of income, except the purchase of capital equipment and payment on the principal of loans for capital assets and durable goods or any cost of depreciation.

g. Child care income. Gross income from providing child care in the applicant's or recipient's own home shall include the total payment(s) received for the service and any payment received due to the Child Nutrition Amendments of 1978 for the cost of providing meals to children.

h. Income verification. The applicant or recipient shall cooperate in supplying verification of all earned income and of any change in income, as defined at rule 441—40.21(239B). A self-employed individual shall keep any records necessary to establish eligibility.

41.27(3) Shared living arrangements. When a family investment program parent shares living arrangements with another family or person, funds combined to meet mutual obligations for shelter and other basic needs are not income. Funds made available to the family investment program eligible group, exclusively for their needs, are considered income.

41.27(4) Diversion of income.

a. Nonexempt earned and unearned income of the parent shall be diverted to meet the unmet needs, including special needs, of the ineligible child(ren) of the parent living in the family group who meets the age and school attendance requirements specified in subrule 41.21(1). Income of the parent shall be diverted to meet the unmet needs of the ineligible child(ren) of the parent and a companion in the home only when the income and resources of the companion and the child(ren) are within family investment program standards. The maximum income that shall be diverted to meet the needs of the ineligible child(ren) shall be the difference between the needs of the eligible group if the ineligible child(ren) were included and the needs of the eligible group with the child(ren) excluded, except as specified in 41.27(8) "a"(2) and 41.27(8) "b."

b. Nonexempt earned and unearned income of the parent shall be diverted to permit payment of court-ordered support to children not living with the parent when the payment is actually being made.

41.27(5) *Income of unmarried specified relatives under age 19.* Treatment of the income of an unmarried specified relative under the age of 19 is determined by whether the specified relative lives with a parent who receives FIP assistance, lives with a nonparental relative, lives in an independent living arrangement, or lives with a self-supporting parent, as follows.

a. Living with a parent on FIP, with a nonparental relative, or in an independent living arrangement.

(1) The income of the unmarried, underage specified relative who is also an eligible child in the grant of the specified relative's parent shall be treated in the same manner as that of any other child. The income for the unmarried, underage specified relative who is not an eligible child in the grant of the specified relative's parent shall be treated in the same manner as though the specified relative had attained majority.

(2) The income of the unmarried, underage specified relative living with a nonparental relative or in an independent living arrangement shall be treated in the same manner as though the specified relative had attained majority.

b. Living with a self-supporting parent. The income of an unmarried specified relative under the age of 19 who is living in the same home as one or both of the person's self-supporting parents shall be treated in accordance with subparagraphs (1), (2), and (4) below.

(1) When the unmarried specified relative is under the age of 18 and not a parent of the dependent child, the income of the specified relative shall be exempt.

(2) When the unmarried specified relative is under the age of 18 and a parent of the dependent child, the income of the specified relative shall be treated in the same manner as though the specified relative had attained majority. The income of the specified relative's self-supporting parent(s) shall be treated in accordance with 41.27(8) "c."

(3) Rescinded IAB 4/3/91, effective 3/14/91.

(4) When the unmarried specified relative is age 18, the income of the specified relative shall be treated in the same manner as though the specified relative had attained majority.

41.27(6) *Exempt as income and resources.* The following shall be exempt as income and resources:

a. Food reserves from home-produced garden products, orchards, domestic animals, and the like, when utilized by the household for its own consumption.

b. The value of the food assistance program benefit.

c. The value of the United States Department of Agriculture donated foods (surplus commodities).

d. The value of supplemental food assistance received under the Child Nutrition Act and the special food service program for children under the National School Lunch Act.

e. Any benefits received under Title III-C, Nutrition Program for the Elderly, of the Older Americans Act.

f. Benefits paid to eligible households under the Low Income Home Energy Assistance Act of 1981.

g. Any payment received under Title II of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 and the Federal-Aid Highway Act of 1968.

h. Any judgment funds that have been or will be distributed per capita or held in trust for members of any Indian tribe. When the payment, in all or part, is converted to another type of resource, that resource is also exempt.

i. Payments to volunteers participating in the Volunteers in Service to America (VISTA) program, except that this exemption will not be applied when the director of ACTION determines that the value of all VISTA payments, adjusted to reflect the number of hours the volunteers are serving, is equivalent to or greater than the minimum wage then in effect under the Fair Labor Standards Act of 1938, or the minimum wage under the laws of the state where the volunteers are serving, whichever is greater.

j. Payments for supporting services or reimbursement of out-of-pocket expenses received by volunteers in any of the programs established under Titles II and III of the Domestic Volunteer Services Act.

k. Tax-exempt portions of payments made pursuant to the Alaskan Native Claims Settlement Act.

- l.* Experimental housing allowance program payments made under annual contribution contracts entered into prior to January 1, 1975, under Section 23 of the U.S. Housing Act of 1936 as amended.
- m.* The income of a supplemental security income recipient.
- n.* Income of an ineligible child.
- o.* Income in-kind.
- p.* Family support subsidy program payments.
- q.* Grants obtained and used under conditions that preclude their use for current living costs.
- r.* All earned and unearned educational funds of an undergraduate or graduate student or a person in training. Any extended social security or veterans benefits received by a parent or nonparental relative as defined at subrule 41.22(3), conditional to school attendance, shall be exempt. However, any additional amount received for the person's dependents who are in the eligible group shall be counted as nonexempt income.
 - s.* Rescinded IAB 2/11/98, effective 2/1/98.
 - t.* Any income restricted by law or regulation which is paid to a representative payee, living outside the home, other than a parent who is the applicant or recipient, unless the income is actually made available to the applicant or recipient by the representative payee.
 - u.* The first \$50 received and retained by an applicant or recipient which represents a current monthly support obligation or a voluntary support payment, paid by a legally responsible individual, but in no case shall the total amount exempted exceed \$50 per month per eligible group.
 - v.* Bona fide loans. Evidence of a bona fide loan may include any of the following:
 - (1) The loan is obtained from an institution or person engaged in the business of making loans.
 - (2) There is a written agreement to repay the money within a specified time.
 - (3) If the loan is obtained from a person not normally engaged in the business of making a loan, there is a borrower's acknowledgment of obligation to repay (with or without interest), or the borrower expresses intent to repay the loan when funds become available in the future, or there is a timetable and plan for repayment.
 - w.* Payments made from the Agent Orange Settlement Fund or any other fund established pursuant to the settlement in the In re Agent Orange product liability litigation, M.D.L. No. 381 (E.D.N.Y.).
 - x.* The income of a person ineligible due to receipt of state-funded foster care, IV-E foster care, or subsidized adoption assistance.
 - y.* Payments for major disaster and emergency assistance provided under the Disaster Relief Act of 1974 as amended by Public Law 100-707, the Disaster Relief and Emergency Assistance Amendments of 1988.
 - z.* Payments made to certain United States citizens of Japanese ancestry and resident Japanese aliens under Section 105 of Public Law 100-383, and payments made to certain eligible Aleuts under Section 206 of Public Law 100-383, entitled "Wartime Relocation of Civilians."
 - aa.* Payments received from the Radiation Exposure Compensation Act.
 - ab.* Deposits into an individual development account (IDA) when determining eligibility and benefit amount. The amount of the deposit is exempt as income and shall not be used in the 185 percent eligibility test. The deposit shall be deducted from nonexempt earned and unearned income that the client receives in the same budget month in which the deposit is made. To allow a deduction, verification of the deposit shall be provided by the end of the report month or the extended filing date, whichever is later. The client shall be allowed a deduction only when the deposit is made from the client's money. The earned income deductions in 41.27(2) "a" and "c" shall be applied to nonexempt earnings from employment or net profit from self-employment that remain after deducting the amount deposited into the account. Allowable deductions shall be applied to any nonexempt unearned income that remains after deducting the amount of the deposit. If the client has both nonexempt earned and unearned income, the amount deposited into the IDA account shall first be deducted from the client's nonexempt unearned income. Deposits shall not be deducted from earned or unearned income that is exempt.
 - ac.* Assigned support collected in a month and retained by child support recovery as described in subparagraph 41.27(1) "h"(2).

41.27(7) *Exempt as income.* The following are exempt as income.

- a. Reimbursements from a third party.
- b. Reimbursement from the employer for job-related expenses.
- c. The following nonrecurring lump sum payments:
 - (1) Income tax refund.
 - (2) Retroactive supplemental security income benefits.
 - (3) Settlements for the payment of medical expenses.
 - (4) Refunds of security deposits on rental property or utilities.
 - (5) That part of a lump sum received and expended for funeral and burial expenses.
 - (6) That part of a lump sum both received and expended for the repair or replacement of resources.
- d. Payments received by the family providing foster care to a child or children when the family is operating a licensed foster home.
- e. Rescinded IAB 5/1/91, effective 7/1/91.
- f. A small monetary nonrecurring gift, such as a Christmas, birthday or graduation gift, not to exceed \$30 per person per calendar quarter.

When a monetary gift from any one source is in excess of \$30, the total gift is countable as unearned income. When monetary gifts from several sources are each \$30 or less, and the total of all gifts exceeds \$30, only the amount in excess of \$30 is countable as unearned income.

- g. Federal or state earned income tax credit.
- h. Supplementation from county funds providing:
 - (1) The assistance does not duplicate any of the basic needs as recognized by the family investment program, or
 - (2) The assistance, if a duplication of any of the basic needs, is made on an emergency basis, not as ongoing supplementation.
- i. Any payment received as a result of an urban renewal or low-cost housing project from any governmental agency.
- j. A retroactive corrective payment.
- k. The training allowance issued by the division of vocational rehabilitation, department of education.
- l. Payments from the PROMISE JOBS program.
- m. Rescinded, effective July 1, 1989.
- n. The training allowance issued by the department for the blind.
- o. Payment(s) from a passenger(s) in a car pool.
- p. Support refunded by the child support recovery unit for the first month of termination of eligibility and the family does not receive the family investment program.
- q. Rescinded IAB 11/8/06, effective 1/1/07.
- r. Rescinded IAB 11/8/06, effective 1/1/07.
- s. Income of a nonparental relative as defined in 41.22(3) except when the relative is included in the eligible group.
- t. Rescinded IAB 11/8/06, effective 1/1/07.
- u. Rescinded IAB 9/11/96, effective 11/1/96.
- v. Compensation in lieu of wages received by a child funded through an employment and training program of the U.S. Department of Labor.
- w. Any amount for training expenses included in a payment funded through an employment and training program of the U.S. Department of Labor.
- x. Rescinded, effective July 1, 1986.
- y. Earnings of an applicant or recipient aged 19 or younger who is a full-time student as defined in 41.24(2)“e.” The exemption applies through the entire month of the person’s twentieth birthday.

EXCEPTION: When the twentieth birthday falls on the first day of the month, the exemption stops on the first day of that month.

- z. Income attributed to an unmarried, underage parent in accordance with 41.27(8)“c” effective the first day of the month following the month in which the unmarried, underage parent turns age 18 or

reaches majority through marriage. When the unmarried, underage parent turns age 18 on the first day of a month, the income of the self-supporting parent(s) becomes exempt as of the first day of that month.

aa. Rescinded IAB 12/3/97, effective 2/1/98.

ab. Incentive payments received from participation in the adolescent pregnancy prevention programs.

ac. Payments received from the comprehensive child development program, funded by the Administration for Children, Youth, and Families, provided the payments are considered complimentary assistance by federal regulation.

ad. Incentive allowance payments received from the work force investment project, provided the payments are considered complimentary assistance by federal regulation.

ae. Interest and dividend income.

af. Rescinded IAB 12/3/97, effective 2/1/98.

ag. Rescinded IAB 11/8/06, effective 1/1/07.

ah. Welfare reform and regular household honorarium income. All moneys paid to a FIP household in connection with the welfare reform demonstration longitudinal study or focus groups shall be exempted.

ai. Diversion or self-sufficiency grants assistance as described at 441—Chapter 47.

aj. Payments from property sold under an installment contract as specified in paragraphs 41.26(4) “b” and 41.27(1) “f.”

ak. All census earnings received by temporary workers from the Bureau of the Census.

41.27(8) *Treatment of income in excluded parent cases, stepparent cases, and underage parent cases.*

a. Treatment of income in excluded parent cases.

(1) A parent who is living in the home with the eligible child(ren) but whose needs are excluded from the eligible group is eligible for the earned income deduction described at paragraph 41.27(2) “a,” the work incentive disregard described at paragraph 41.27(2) “c,” and diversions described at subrule 41.27(4).

(2) The excluded parent shall be permitted to retain that part of the parent’s income to meet the parent’s needs as determined by the difference between the needs of the eligible group with the parent included and the needs of the eligible group with the parent excluded except as described at subrule 41.27(11).

(3) All remaining income of the excluded parent shall be applied against the needs of the eligible group.

b. Treatment of income in stepparent cases. The income of a stepparent who is not included in the eligible group, but is living with the parent in the home of the eligible child(ren), shall be given the same consideration and treatment as that of a parent subject to the limitations of subparagraphs (1) to (10) below.

(1) The stepparent’s monthly gross nonexempt earned income, earned as an employee or monthly net profit from self-employment, shall receive a 20 percent earned income deduction.

(2) Rescinded IAB 6/30/99, effective 7/1/99.

(3) Any amounts actually paid by the stepparent to individuals not living in the home, who are claimed or could be claimed by the stepparent as dependents for federal income tax purposes, shall be deducted from nonexempt monthly earned and unearned income of the stepparent.

(4) The stepparent shall also be allowed a deduction from nonexempt monthly earned and unearned income for alimony and child support payments made to individuals not living in the home with the stepparent.

(5) Except as described at 41.27(11), the nonexempt monthly earned and unearned income of the stepparent remaining after application of the deductions in 41.27(8) “b”(1) to (4) above shall be used to meet the needs of the stepparent and the stepparent’s dependents living in the home, when the dependents’ needs are not included in the eligible group and the stepparent claims or could claim the dependents for federal income tax purposes. These needs shall be determined in accordance with the family investment program standard of need for a family group of the same composition.

(6) The stepparent shall be allowed the work incentive disregard described at paragraph 41.27(2)“c” from monthly earnings. The disregard shall be applied to earnings that remain after all other deductions in subparagraphs 41.27(8)“b”(1) through (5) have been subtracted from the earnings. However, the work incentive disregard is not allowed when determining initial eligibility as described at subparagraphs 41.27(9)“a”(2) and (3).

(7) The deductions described in subparagraphs (1) through (6) will first be subtracted from earned income in the same order as they appear above.

When the stepparent has both nonexempt earned and unearned income and earnings are less than the allowable deductions, then any remaining portion of the deductions in subparagraphs (3) through (5) shall be subtracted from unearned income. Any remaining income shall be applied as unearned income to the needs of the eligible group.

If the stepparent has earned income remaining after allowable deductions, then any nonexempt unearned income shall be added to the earnings and the resulting total counted as unearned income to the needs of the eligible group.

(8) A nonexempt nonrecurring lump sum received by a stepparent shall be considered as income in the month received. Any portion of the nonrecurring lump sum retained by the stepparent in the month following the month of receipt shall be considered a resource to the stepparent.

(9) When the income of the stepparent, not in the eligible group, is insufficient to meet the needs of the stepparent and the stepparent’s dependents living in the home who are not eligible for FIP, the income of the parent may be diverted to meet the unmet needs of the child(ren) of the current marriage except as described at 41.27(11).

(10) When the needs of the stepparent, living in the home, are not included in the eligible group, the eligible group and any child(ren) of the parent living in the home who is not eligible for FIP shall be considered as one unit, and the stepparent and the stepparent’s dependents, other than the spouse, shall be considered a separate unit.

(11) Rescinded IAB 6/30/99, effective 9/1/99.

c. Treatment of income in underage parent cases. In the case of a dependent child whose unmarried parent is under the age of 18 and living in the same home as the unmarried, underage parent’s own self-supporting parent(s), the income of each self-supporting parent shall be considered available to the eligible group after appropriate deductions. The deductions to be applied are the same as are applied to the income of a stepparent pursuant to 41.27(8)“b”(1) to (7). Nonrecurring lump sum income received by the self-supporting parent(s) shall be treated in accordance with 41.27(8)“b”(8).

When the self-supporting spouse of a self-supporting parent is also living in the home, the income of that spouse shall be attributable to the self-supporting parent in the same manner as the income of a stepparent is determined pursuant to 41.27(8)“b”(1) to (7). Nonrecurring lump sum income received by the spouse of the self-supporting parent shall be treated in accordance with 41.27(8)“b”(8). The self-supporting parent and any ineligible dependents of that person shall be considered as one unit; the self-supporting spouse and the spouse’s ineligible dependents, other than the self-supporting parent, shall be considered a separate unit.

41.27(9) Budgeting process. Both initial and ongoing eligibility and benefits shall be determined using a projection of income based on the best estimate of future income.

a. Initial eligibility.

(1) At time of application, all earned and unearned income received and anticipated to be received by the eligible group during the month the decision is made shall be considered to determine eligibility for the family investment program, except income which is exempt. All countable earned and unearned income received by the eligible group during the 30 days before the interview shall be used to project future income. If the applicant indicates that the 30-day period is not indicative of future income, income from a longer period or verification of anticipated income from the income source may be used to project future income.

When income is prorated in accordance with 41.27(9)“c”(1) and 41.27(9)“i,” the prorated amount is counted as income received in the month of decision. Allowable work expenses during the month of decision shall be deducted from earned income, except when determining eligibility under the 185

percent test defined in rule 441—41.27(239B). The determination of eligibility in the month of decision is a three-step process as described in rule 441—41.27(239B).

(2) When countable gross nonexempt earned and unearned income in the month of decision, or in any other month after assistance is approved, exceeds 185 percent of the standard of need for the eligible group, the application shall be rejected or the assistance grant canceled. Countable gross income means nonexempt gross income, as defined in rule 441—41.27(239B), without application of any disregards, deductions, or diversions. When the countable gross nonexempt earned and unearned income in the month of decision equals or is less than 185 percent of the standard of need for the eligible group, initial eligibility under the standard of need shall then be determined. Initial eligibility under the standard of need is determined without application of the work incentive disregard as specified in paragraph 41.27(2) “c.” All other appropriate exemptions, deductions and diversions are applied. Countable income is then compared to the standard of need for the eligible group. When countable net earned and unearned income in the month of decision equals or exceeds the standard of need for the eligible group, the application shall be denied.

(3) When the countable net income in the month of decision is less than the standard of need for the eligible group, the work incentive disregard described in paragraph 41.27(2) “c” shall be applied when there is eligibility for this disregard. When countable net earned and unearned income in the month of decision, after application of the work incentive disregard and all other appropriate exemptions, deductions, and diversions, equals or exceeds the payment standard for the eligible group, the application shall be denied.

When the countable net income in the month of decision is less than the payment standard for the eligible group, the eligible group meets income requirements. The amount of the family investment program grant shall be determined by subtracting countable net income in the month of decision from the payment standard for the eligible group, except as specified in subparagraph 41.27(9) “a”(4).

(4) Eligibility for the family investment program for any month or partial month before the month of decision shall be determined only when there is eligibility in the month of decision. The family composition for any month or partial month before the month of decision shall be considered the same as on the date of decision. In determining eligibility and the amount of the assistance payment for any month or partial month preceding the month of decision, income and all circumstances except family composition in that month shall be considered in the same manner as in the month of decision. When the applicant is eligible for some, but not all, months of the application period due to the time limit described at subrule 41.30(1), family investment program eligibility shall be determined for the month of decision first, then the immediately preceding month, and so on until the time limit has been reached.

(5) Rescinded IAB 11/8/06, effective 1/1/07.

(6) Rescinded IAB 11/8/06, effective 1/1/07.

(7) Rescinded IAB 7/4/07, effective 8/1/07.

b. Ongoing eligibility.

(1) The department shall prospectively compute eligibility and benefits when review information is submitted as described in 441—subrule 40.27(3). All countable earned and unearned income received by the eligible group during the previous 30 days shall be used to project future income. If the participant indicates that the 30-day period is not indicative of future income, income from a longer period or verification of anticipated income from the income source may be used to project future income.

(2) When a change in eligibility factors occurs, the department shall prospectively compute eligibility and benefits based on the change, effective no later than the month following the month the change occurred.

(3) Rescinded IAB 11/8/06, effective 1/1/07.

(4) The earned income deduction for each wage earner as defined in paragraph 41.27(2) “a” and the work incentive disregard as defined in paragraph 41.27(2) “c” shall be allowed.

c. Lump-sum income.

(1) Recurring lump-sum income. Recurring lump-sum earned and unearned income, except for the income of the self-employed, shall be considered as income in the month received. Income received by an individual employed under a contract shall be prorated over the period of the contract. Income received at

periodic intervals or intermittently shall be considered as income in the month received, except periodic or intermittent income from self-employment shall be treated as described in 41.27(9) "i." When the income that is subject to proration is earned, appropriate disregards, deductions and diversions shall be applied to the monthly prorated income. Income that is subject to proration is prorated when a lump sum is received before the month of decision and is anticipated to recur; or a lump sum is received during the month of decision or at any time during the receipt of assistance.

(2) Nonrecurring lump-sum income. Moneys received as a nonrecurring lump sum, except as specified in subrules 41.26(4), 41.26(7), 41.27(8) "b," and 41.27(8) "c," shall be treated in accordance with this rule. Nonrecurring lump-sum income shall be considered as income in the month received and counted in computing eligibility and the amount of the grant, unless the income is exempt. Nonrecurring lump-sum unearned income is defined as a payment in the nature of a windfall, for example, an inheritance, an insurance settlement for pain and suffering, an insurance death benefit, a gift, lottery winnings, or a retroactive payment of benefits, such as social security, job insurance or workers' compensation. When countable income, exclusive of the family investment program grant but including countable lump-sum income, exceeds the needs of the eligible group, the case shall be canceled or the application rejected. In addition, the eligible group shall be ineligible for the number of full months derived by dividing the income by the standard of need for the eligible group. Any income remaining after this calculation shall be applied as income to the first month following the period of ineligibility and disregarded as income thereafter. The period of ineligibility shall begin with the month the lump sum is received.

When a nonrecurring lump sum is timely reported as required by 441—paragraph 40.27(4) "f," recoupment shall not be made for the month of receipt. When a nonrecurring lump sum is timely reported, but the timely notice as required by rule 441—7.7(17A) requires the action be delayed until the second calendar month following the month of change, recoupment shall not be made for the first calendar month following the month of change. When a nonrecurring lump sum is not timely reported, recoupment shall be made beginning with the month of receipt.

The period of ineligibility shall be shortened when the schedule of living costs as defined in 41.28(2) increases.

The period of ineligibility shall be shortened by the amount that is no longer available to the eligible group due to a loss or a theft or because the person controlling the lump sum no longer resides with the eligible group.

The period of ineligibility shall also be shortened when there is an expenditure of the lump sum made for the following circumstances unless there was insurance available to meet the expense: Payments made on medical services for the former eligible group or their dependents for services listed in 441—Chapters 78, 81, 82 and 85 at the time the expense is reported to the department; the cost of necessary repairs to maintain habitability of the homestead requiring the spending of over \$25 per incident; cost of replacement of exempt resources as defined in subrule 41.26(1) due to fire, tornado, or other natural disaster; or funeral and burial expenses. The expenditure of these funds shall be verified. A dependent is an individual who is claimed or could be claimed by another individual as a dependent for federal income tax purposes.

When countable income, including the lump-sum income, is less than the needs of the eligible group, the lump sum shall be counted as income for the month received. For purposes of applying the lump-sum provision, the eligible group is defined as all eligible persons and any other individual whose lump-sum income is counted in determining the period of ineligibility. During the period of ineligibility, individuals not in the eligible group when the lump-sum income was received may be eligible for the family investment program as a separate eligible group. Income of this eligible group plus income, excluding the lump-sum income already considered, of the parent or other legally responsible person in the home shall be considered as available in determining eligibility and the amount of the grant.

d. The third digit to the right of the decimal point in any computation of income and hours of employment shall be dropped. This includes the calculation of the amount of a child support sanction as defined in paragraph 41.22(6) "f."

e. In any month for which an individual is determined eligible to be added to a currently active family investment program case, the individual's needs shall be included subject to the effective date of grant limitations as prescribed in 441—40.26(239B).

(1) When adding an individual to an existing eligible group, any income of that individual shall be considered prospectively.

(2) The needs of an individual determined to be ineligible to remain a member of the eligible group shall be removed prospectively effective the first of the following month.

f. Rescinded IAB 11/8/06, effective 1/1/07.

g. When income received weekly or biweekly (once every two weeks) is projected for future months, it shall be projected by adding all income received in the period being used and dividing the result by the number of instances of income received in that period. The result shall be multiplied by four if the income is received weekly or by two if the income is received biweekly, regardless of the number of weekly or biweekly payments to be made in future months.

h. Income from self-employment received on a regular weekly, biweekly, semimonthly or monthly basis shall be budgeted in the same manner as the earnings of an employee. The countable income shall be the net income.

i. Income from self-employment not received on a regular weekly, biweekly, semimonthly or monthly basis that represents an individual's annual income shall be averaged over a 12-month period of time, even if the income is received within a short period of time during that 12-month period. Any change in self-employment shall be handled in accordance with subparagraphs (3), (4), and (5) below.

(1) When a self-employment enterprise which does not produce a regular weekly, biweekly, semimonthly or monthly income has been in existence for less than a year, income shall be averaged over the period of time the enterprise has been in existence and the monthly amount projected for the same period of time. If the enterprise has been in existence for such a short time that there is very little income information, the worker shall establish, with the cooperation of the client, a reasonable estimate which shall be considered accurate and projected for three months, after which the income shall be averaged and projected for the same period of time. Any changes in self-employment shall be considered in accordance with subparagraphs (3), (4) and (5) below.

(2) These policies apply when the self-employment income is received before the month of decision and the income is expected to continue, in the month of decision, and after assistance is approved.

(3) A change in the cost of producing self-employment income is defined as an established permanent ongoing change in the operating expenses of a self-employment enterprise. Change in self-employment income is defined as a change in the nature of business.

(4) When a change in operating expenses occurs, the department shall recompute the expenses on the basis of the change.

(5) When a change occurs in the nature of the business, the income and expenses shall be computed on the basis of the change.

j. Special needs.

(1) A special need as defined in 41.28(3) must be documented before payment shall be made.

(2) A one-time special need occurs and is considered in determining need for the calendar month in which the special need is entered on the automated benefit calculation system.

(3) An ongoing special need is considered in determining need for the calendar month following the calendar month in which the special need is entered on the automated benefit calculation system.

(4) When the special need continues, payment shall be included, prospectively, in each month's family investment program grant. When the special need ends, payment shall be removed prospectively. Any overpayment for a special need shall be recouped.

(5) Rescinded IAB 11/8/06, effective 1/1/07.

k. When a family's assistance for a month is subject to recoupment because the family was not eligible, individuals applying for assistance during the same month may be eligible for the family investment program as a separate eligible group. Income of this new eligible group plus income of the parent or other legally responsible person in the home shall be considered as available in determining

eligibility and the amount of the grant. The income of an ineligible parent or other legally responsible person shall be considered prospectively in accordance with 41.27(4) and 41.27(8).

41.27(10) *Aliens sponsored by individuals.* When an alien admitted for lawful permanent residence is sponsored by a person who executed an enforceable affidavit of support as described in 8 U.S.C. Section 1631(a)(1) on behalf of the alien, the income of the alien shall be deemed to include the income of the sponsor (and of the sponsor's spouse if living with the sponsor). The amount of the income of the sponsor and the sponsor's spouse deemed to the alien shall be the total gross earned and unearned income remaining after allowing the earned income deduction described at paragraph 41.27(2) "a," the work incentive disregard described at paragraph 41.27(2) "c," and diversions described at subrule 41.27(4). The following are exceptions to deeming of a sponsor's income:

a. Deeming of the sponsor's income does not apply when:

(1) The sponsored alien attains citizenship through naturalization pursuant to Chapter 2 of Title III of the Immigration and Nationality Act;

(2) The sponsored alien has earned 40 qualifying quarters of coverage as defined in Title II of the Social Security Act or can be credited with 40 qualifying quarters as defined at rule 441—40.21(239B); or

(3) The sponsored alien or the sponsor dies.

b. An indigent alien is exempt from the deeming of a sponsor's income for 12 months after indigence is determined. An alien shall be considered indigent if:

(1) The alien does not live with the sponsor; and

(2) The alien's gross income, including any income received from or made available by the sponsor, is less than 100 percent of the federal poverty level for the sponsored alien's household size.

c. A battered alien as described in 8 U.S.C. Section 1641(c) is exempt from the deeming of a sponsor's income for 12 months.

41.27(11) *Restriction on diversion of income.* No income may be diverted to meet the needs of a person living in the home who has been sanctioned under subrule 41.24(8) or 41.25(5), or who has been disqualified under subrule 41.25(10) or rule 441—46.29(239B), or who is required to be included in the eligible group according to 41.28(1) "a" and has failed to cooperate. This restriction applies to 41.27(4) "a" and 41.27(8).

This rule is intended to implement Iowa Code section 239B.7.

[ARC 8500B, IAB 2/10/10, effective 3/1/10; ARC 9043B, IAB 9/8/10, effective 11/1/10; ARC 9439B, IAB 4/6/11, effective 6/1/11; ARC 0148C, IAB 6/13/12, effective 8/1/12; ARC 1478C, IAB 6/11/14, effective 8/1/14]

441—41.28(239B) Need standards.

41.28(1) *Definition of the eligible group.* The eligible group consists of all eligible people specified below and living together, except when one or more of these people receive supplemental security income under Title XVI of the Social Security Act. There shall be at least one child in the eligible group except when the only eligible child is receiving supplemental security income. The unborn child is not considered a member of the eligible group for purposes of establishing the number of people in the eligible group.

a. The following persons shall be included (except as otherwise provided in these rules), without regard to the person's employment status, income or resources:

(1) All dependent children who are siblings of whole or half blood or adoptive.

(2) Any parent of such children, if the parent is living in the same home as the dependent children.

b. The following persons may be included:

(1) The needy specified relative who assumes the role of parent.

(2) The needy specified relative who acts as payee when the parent is in the home, but is unable to act as payee.

(3) An incapacitated stepparent, upon request, when the stepparent is the legal spouse of the parent by ceremonial or common-law marriage and the incapacitated stepparent does not have a child in the eligible group.

1. A stepparent is considered incapacitated when a clearly identifiable physical or mental defect has a demonstrable effect upon earning capacity or the performance of the homemaking duties required to maintain a home for the stepchild. The incapacity shall be expected to last for a period of at least 30 days from the date of application.

2. The determination of incapacity shall be supported by medical or psychological evidence. The evidence may be obtained from either an independent physician or psychologist or the state rehabilitation agency. The evidence may be submitted either by letter from the physician or on Form 470-0447, Report on Incapacity. When an examination is required and other resources are not available to meet the expense of the examination, the physician shall be authorized to make the examination and submit the claim for payment on Form 470-0502, Authorization for Examination and Claim for Payment. A finding of eligibility for social security benefits or supplemental security income benefits based on disability or blindness is acceptable proof of incapacity.

(4) Rescinded IAB 6/30/99, effective 7/1/99.

41.28(2) Schedule of needs. The schedule of living costs represents 100 percent of basic needs. The schedule of living costs is used to determine the needs of individuals when these needs must be determined in accordance with the standard of need defined in 441—40.21(239B). The 185 percent schedule is included for the determination of eligibility in accordance with 441—41.27(239B). The schedule of basic needs is used to determine the basic needs of those persons whose needs are included in and are eligible for a family investment program grant. The eligible group is considered a separate and distinct group without regard to the presence in the home of other persons, regardless of relationship to or whether they have a liability to support members of the eligible group. The schedule of basic needs is also used to determine the needs of persons not included in the assistance grant, when these needs must be determined in accordance with the payment standard defined in 441—40.21(239B). The percentage of basic needs paid to one or more persons as compared to the schedule of living costs is shown on the chart below.

SCHEDULE OF NEEDS

[illegible]

CHART OF BASIC NEEDS COMPONENTS

(all figures are on a per person basis)

Number of Persons	1	2	3	4	5	6	7	8	9	10 or More
Shelter	77.14	65.81	47.10	35.20	31.74	26.28	25.69	22.52	20.91	20.58
Utilities	19.29	16.45	11.77	8.80	7.93	6.57	6.42	5.63	5.23	5.14
Household Supplies	4.27	5.33	4.01	3.75	3.36	3.26	3.10	3.08	2.97	2.92
Food	34.49	44.98	40.31	39.11	36.65	37.04	34.00	33.53	32.87	32.36
Clothing	11.17	11.49	8.70	8.75	6.82	6.84	6.54	6.39	6.20	6.10
Pers. Care & Supplies	3.29	3.64	2.68	2.38	2.02	1.91	1.82	1.72	1.67	1.64
Med. Chest Supplies	.99	1.40	1.34	1.13	1.15	1.11	1.08	1.06	1.09	1.08
Communi-cations	7.23	6.17	3.85	3.25	2.50	2.07	1.82	1.66	1.51	1.49
Transportation	25.13	25.23	22.24	21.38	17.43	16.59	15.24	15.79	15.44	15.19

a. The definitions of the basic need components are as follows:

- (1) Shelter: Rental, taxes, upkeep, insurance, amortization.
- (2) Utilities: Fuel, water, lights, water heating, refrigeration, garbage.
- (3) Household supplies and replacements: Essentials associated with housekeeping and meal preparation.
- (4) Food: Including school lunches.
- (5) Clothing: Including layette, laundry, dry cleaning.
- (6) Personal care and supplies: Including regular school supplies.
- (7) Medicine chest items.
- (8) Communications: Telephone, newspapers, magazines.
- (9) Transportation: Includes bus fares and other out-of-pocket costs of operating a privately owned vehicle.

b. Special situations in determining eligible group:

(1) The needs of a child or children in a nonparental home shall be considered a separate eligible group when the relative is receiving the family investment program assistance for the relative's own children.

(2) When the unmarried specified relative under age 19 is living in the same home with a parent or parents who receive the family investment program, the needs of the specified relative, when eligible, shall be included in the same eligible group with the parent(s). When the specified relative is a parent, the needs of the eligible children for whom the unmarried parent is caretaker shall be included in the same eligible group. When the specified relative is a nonparental relative, the needs of the eligible children for whom the specified relative is caretaker shall be considered a separate eligible group.

When the unmarried specified relative under the age of 19 is living in the same home as a parent(s) who receives the family investment program but the specified relative is not an eligible child, need of the specified relative shall be determined in the same manner as though the specified relative had attained majority.

When the unmarried specified relative under the age of 19 is living with a nonparental relative or in an independent living arrangement, need shall be determined in the same manner as though the specified relative had attained majority.

When the unmarried specified relative is under the age of 18 and living in the same home with a parent(s) who does not receive the family investment program, the needs of the specified relative, when eligible, shall be included in the assistance grant with the children when the specified relative is a parent. When the specified relative is a nonparental relative as defined in 41.22(3), only the needs of the eligible

children shall be included in the assistance grant. When the unmarried specified relative is aged 18, need shall be determined in the same manner as though the specified relative had attained majority.

(3) When a person who would ordinarily be in the eligible group is receiving supplemental security income benefits, the person, income, and resources shall not be considered in determining family investment program benefits for the rest of the family.

(4) When two individuals, married to each other, are living in a common household and the children of each of them are recipients of assistance, the assistance grant shall be computed on the basis of their comprising one eligible group. This rule shall not be construed to require that an application for assistance be made for children who are not the natural or adoptive children of the applicant.

41.28(3) *Special needs.* On the basis of demonstrated need the following special needs shall be allowed, in addition to the basic needs.

a. School expenses. Any specific charge, excluding tuition, for a child's education made by the school, or in accordance with school requirements in connection with a course in the curriculum, shall be allowed provided the allowance shall not exceed the reasonable cost required to meet the specifications of the course, and the student is actually participating in the course at the time the expense is claimed. Payment will not be made for ordinary expenses for school supplies.

b. Guardian/conservator fee. An amount not to exceed \$10 per case per month may be allowed for guardian's/conservator's fees when authorized by appropriate court order. No additional payment is permitted for court costs or attorney's fees.

c. FIP special needs classroom training. Rescinded IAB 12/3/97, effective 2/1/98.

d. Job Training Partnership Act. Rescinded IAB 12/3/97, effective 2/1/98.

41.28(4) *Period of adjustment.* Rescinded IAB 11/1/00, effective 1/1/01.

This rule is intended to implement Iowa Code section 239B.5.

441—41.29(239B) Composite FIP/SSI cases. When persons in the family investment program household, who would ordinarily be in the eligible group, are receiving supplemental security income benefits, the following rules shall apply.

41.29(1) *Pending SSI approval.* When a person who would ordinarily be in the eligible group has applied for supplemental security income benefits, the person's needs may be included in the family investment program grant pending approval of supplemental security income.

41.29(2) *Ownership of property.* When property is owned by both the supplemental security income beneficiary and the family investment program recipient, each shall be considered as having a half interest in order to determine the value of the resource, unless the terms of the deed or purchase contract clearly establish ownership on a different proportional basis.

This rule is intended to implement Iowa Code section 239B.5.

441—41.30(239B) Time limits.

41.30(1) *Sixty-month limit.* Assistance shall not be provided to a FIP applicant or recipient family that includes an adult who has received assistance for 60 calendar months under FIP or any state program in Iowa or in another state that is funded by the Temporary Assistance for Needy Families (TANF) block grant. The 60-month period need not be consecutive.

a. An "adult" is any person who is a parent of the FIP child in the home, the parent's spouse, or included as an optional member under subparagraphs 41.28(1) "b"(1), (2) and (3). In two-parent households or households that include a parent and a stepparent, the 60-month limit is determined when either a parent or stepparent has received assistance for 60 months.

b. "Assistance" shall include any month for which the adult receives a FIP grant. Assistance received for a partial month shall count as a full month.

41.30(2) *Determining number of months.*

a. In determining the number of months an adult received assistance, the department shall consider toward the 60-month limit:

(1) Assistance received even when the parent is excluded from the grant unless the parent, or both parents in a two-parent household, are supplemental security income (SSI) recipients.

(2) Assistance received by an optional member of the eligible group as described in subparagraphs 41.28(1) “b”(1) and (2). However, once the person has received assistance for 60 months, the person is ineligible but assistance may continue for other persons in the eligible group. The entire family is ineligible for assistance when the optional member who has received assistance for 60 months is the incapacitated stepparent on the grant as described at subparagraph 41.28(1) “b”(3).

b. When the parent, or both parents in a two-parent household, have received 60 months of FIP assistance and are subsequently approved for supplemental security income, FIP assistance for the children may be granted, if all other eligibility requirements are met.

c. When a minor parent and child receive FIP on the adult parent’s case and the adult parent is no longer eligible due to the 60-month limit on FIP assistance, the minor parent may reapply for FIP as a minor parent living with a self-supporting parent.

d. In determining the number of months an adult received assistance, the department shall not consider toward the 60-month limit any month for which FIP assistance was not issued for the family, such as:

(1) A month of suspension.

(2) A month for which no grant is issued due to the limitations described in rules 441—45.26(239B) and 441—45.27(239B).

(3) Rescinded IAB 1/9/02, effective 3/1/02.

(4) Rescinded IAB 1/9/02, effective 3/1/02.

e. The department shall not consider toward the 60-month limit months of assistance a parent or pregnant person received as a minor child and not as the head of a household or married to the head of a household. This includes assistance received for a minor parent for any month in which the minor parent was a child on the adult parent’s or the specified relative’s FIP case.

f. The department shall not consider toward the 60-month limit months of assistance received by an adult while living in Indian country (as defined in 18 United States Code Section 1151) or a Native Alaskan village where at least 50 percent of the adults were not employed.

41.30(3) Exception to the 60-month limit. A family may receive FIP assistance for more than 60 months as defined in subrule 41.30(1) if the family qualifies for a hardship exemption as described in this subrule. “Hardship” is defined as a circumstance that is preventing the family from being self-supporting. However, the family’s safety shall take precedence over the goal of self-sufficiency.

a. Exclusions. Families with an adult as defined in subrule 41.30(1) who is not a U.S. citizen or a qualified alien as defined in rule 441—40.21(239B) are prohibited from receiving more than 60 months of FIP assistance. The family of an adult who is a nonqualified alien cannot meet the requirements of paragraph “g” of this subrule since the department is precluded from using public funds to provide a nonqualified alien with family investment agreement or PROMISE JOBS services by Iowa Code sections 239B.8 and 239B.18 and rule 441—41.24(239B).

b. Eligibility determination. Eligibility for the hardship exemption shall be determined on an individual family basis. A hardship exemption shall not begin until the adult in the family has received at least 60 months of FIP assistance.

c. Hardship exemption criteria. Circumstances that may lead to a hardship exemption may include, but are not limited to, the following:

(1) Domestic violence. “Domestic violence” means that the family includes someone who has been battered or subjected to extreme cruelty. It includes:

1. Physical acts that resulted in, or threatened to result in, physical injury to the individual.

2. Sexual abuse.

3. Sexual activity involving a dependent child.

4. Being forced as the caretaker relative of a dependent child to engage in nonconsensual sexual acts or activities.

5. Threats of, or attempts at, physical or sexual abuse.

6. Mental abuse.

7. Neglect or deprivation of medical care.

(2) Lack of employability.

- (3) Lack of suitable child care as defined in 441—subrule 93.4(5).
 - (4) Chronic or recurring medical conditions or mental health issues, or an accident or disease, when verified by a professional. The applicant or recipient shall follow a treatment plan to address the condition or issue.
 - (5) Housing situations that make it difficult or impossible to work.
 - (6) Substance abuse issues. A family requesting a hardship exemption due to substance abuse shall be required to obtain clinical assessment and follow an intensive treatment plan.
 - (7) Having a child whose circumstances require the parent to be in the home. This may include, but is not limited to, a child as defined in rule 441—170.1(234) or a child receiving child welfare, juvenile court or juvenile justice services. The safety of the child shall take precedence over the goal of self-sufficiency.
 - (8) Rescinded IAB 1/8/03, effective 1/1/03.
 - (9) Other circumstances which prevent the family from being self-supporting.
- d. Eligibility for a hardship exemption.
- (1) Families may be eligible for a hardship exemption when circumstances prevent the family from being self-supporting. The hardship condition shall be a result of a past or current experience that is affecting the family's current functioning. Current experience may include fear of an event that is likely to occur in the future. The definition of the hardship barrier relies upon the impact of the circumstances upon the family's ability to leave FIP rather than the type of circumstances.
 - (2) Families determined eligible for more than 60 months of FIP shall make incremental steps toward overcoming the hardship and participate to their maximum potential in activities reasonably expected to result in self-sufficiency.
 - (3) Barriers to economic self-sufficiency that were known and existing before the family reached the 60-month limit shall not be considered as meeting eligibility criteria for hardship unless the individual complied with PROMISE JOBS activities offered to overcome that specific barrier.
- e. Requesting a hardship exemption.
- (1) Families with adults as defined in subrule 41.30(1) who have or are close to having received 60 months of FIP assistance may request a hardship exemption. Requests for the hardship exemption shall be made on Form 470-3826, Request for FIP Beyond 60 Months. In addition, families that have received FIP for 60 months shall complete Form 470-0462 or Form 470-0462(S), Financial Support Application, as described at rule 441—40.22(239B) as a condition for regaining FIP eligibility. Failure to provide the required application within ten days from the date of the department's request shall result in denial of the hardship request.
 - (2) In families that request FIP beyond 60 months, all adults as defined in subrule 41.30(1) shall sign the request. When the adult is incompetent or incapacitated, someone acting responsibly on the adult's behalf may sign the request.
 - (3) Requests for a hardship exemption shall not be accepted prior to the first day of the family's fifty-ninth month of FIP assistance. The date of the request shall be the date an identifiable Form 470-3826 is received in any department of human services or PROMISE JOBS office. An identifiable form is one that contains a legible name and address and that has been signed.
 - (4) To receive more than 60 months of FIP assistance, families must be eligible for a hardship exemption and meet all other FIP eligibility requirements.
 - (5) When an adult as defined in subrule 41.30(1) who has received FIP for 60 months joins a recipient family that has not received 60 months of FIP assistance, eligibility shall continue only if the recipient family submits Form 470-3826 and is approved for a hardship exemption as described in subrule 41.30(3) and meets all other FIP eligibility requirements.
 - (6) When an adult as defined in subrule 41.30(1) joins a recipient family that is in an exemption period, the current exemption period shall continue, if the recipient family continues to meet all other eligibility requirements, regardless of whether the joining adult has received FIP for 60 months.
 - (7) When two parents who are in a hardship exemption period separate, the remainder of the exemption period, if there is a need, shall follow the parent who retains the current FIP case.
- f. Determination of hardship exemption.

(1) A determination on the request shall be made as soon as possible, but no later than 30 days following the date an identifiable Form 470-3826 is received in any department of human services or PROMISE JOBS office. A written notice of decision shall be issued to the family the next working day following a determination of eligibility or ineligibility for a hardship exemption.

The 30-day time standard shall apply except in unusual circumstances, such as when the department and the family have made every reasonable effort to secure necessary information which has not been supplied by the date the time limit expired; or because of emergency situations, such as fire, flood or other conditions beyond the administrative control of the department.

(2) When a Financial Support Application is required to regain FIP eligibility, the 30-day time frame in rule 441—40.25(239B) shall apply.

(3) Income maintenance shall determine eligibility for a hardship exemption.

(4) The family shall provide supporting evidence of the hardship barrier and the impact of the barrier upon the family's ability to leave FIP. The department shall advise the applicant or recipient about how to obtain necessary documents. Upon request, the department shall provide reasonable assistance in obtaining supporting documents when the family is not reasonably able to obtain the documents. The type of supporting evidence is dependent upon the circumstance that creates the hardship barrier.

(5) Examples of types of supporting evidence may include:

1. Court, medical, criminal, child protective services, social services, psychological, or law enforcement records.

2. Statements from professionals or other individuals with knowledge of the hardship barrier.

3. Statements from vocational rehabilitation or other job training professionals.

4. Statements from individuals other than the applicant or recipient with knowledge of the hardship circumstances. Written statements from friends and relatives alone may not be sufficient to grant hardship status, but may be used to support other evidence.

5. Court, criminal, police records or statements from domestic violence counselors may be used to substantiate hardship. Living in a domestic violence shelter shall not automatically qualify an individual for a hardship exemption, but would be considered strong evidence.

6. Actively pursuing verification of a disability through the Social Security Administration may not be sufficient to grant hardship status, but may be used to support other evidence.

(6) The department shall notify the family in writing of additional information or verification that is required to verify the barrier and its impact upon the family's ability to leave FIP. The family shall be allowed ten days to supply the required information or verification. The ten-day period may be extended under the circumstances described in 441—subrule 40.24(1) or 441—paragraph 40.27(4)“c.” Failure to supply the required information or verification, or refusal by the family to authorize the department to secure the information or verification from other sources, shall result in denial of the family's request for a hardship exemption.

(7) Rescinded IAB 12/12/01, effective 11/14/01.

(8) Rescinded IAB 12/12/01, effective 11/14/01.

(9) Recipients whose FIP assistance is canceled at the end of the sixtieth month shall be eligible for reinstatement as described at 441—subrule 40.22(5) when Form 470-3826 is received before the effective date of cancellation even if eligibility for a hardship exemption is not determined until on or after the effective date of cancellation.

(10) When Form 470-3826 is not received before the effective date of the FIP cancellation and a Financial Support Application is required for the family to regain FIP eligibility, the effective date of assistance shall be no earlier than seven days from the date of application as described at rule 441—40.26(239B).

(11) Eligibility for a hardship exemption shall last for six consecutive calendar months. EXCEPTION: The six-month hardship exemption ends when FIP for the family is canceled for any reason and a Financial Support Application is required for the family to regain FIP eligibility. In addition, when FIP eligibility depends on receiving a hardship exemption, the family shall submit a new Form 470-3826. A new hardship exemption determination shall be required prior to FIP approval.

(12) FIP received for a partial month of the six-month hardship exemption period shall count as a full month.

(13) There is no limit on the number of hardship exemptions a family may receive over time.

g. Six-month family investment agreement (FIA). Families who request a hardship exemption shall develop and sign a six-month family investment agreement (FIA) as defined at rule 441—93.4(239B) to address the circumstances that are creating the barrier. All adults as defined in subrule 41.30(1) shall sign the six-month FIA unless the adult is a stepparent and is not requesting assistance or is exempt as specified at subrule 41.24(2).

(1) The six-month FIA shall contain specific steps to enable the family to make incremental progress toward overcoming the barrier. Each subsequent hardship exemption shall require a new six-month FIA. Failure to develop or sign a six-month FIA shall result in denial of the family's hardship exemption request.

(2) Families that request a hardship exemption shall be notified verbally and shall be hand-issued the notice of a scheduled appointment for orientation and FIA development. If the notice of appointment cannot be hand-issued, at least five working days shall be allowed from the date the notice is mailed for a participant to appear for the scheduled appointment for orientation and FIA development unless the participant agrees to an appointment that is scheduled to take place in less than five working days.

(3) Failure to attend a scheduled interview when required, except for reasons beyond the adult's control, shall result in a denial of the family's hardship exemption request. In two-parent families, both parents shall be required to participate in any scheduled interview. When the adult is incompetent or incapacitated, someone acting responsibly on the adult's behalf may participate in the interview.

(4) PROMISE JOBS staff shall provide necessary supportive services as described in 441—Chapter 93 and shall monitor the six-month FIA. Periodic contacts shall be made with the family at least once a month. These contacts need not be in person. Time and attendance reports shall be required as specified at 441—subrule 93.10(2).

(5) The six-month FIA shall be renegotiated and amended under the circumstances described at 441—subrule 93.4(8).

(6) Any family that has been granted a hardship exemption and that does not follow the terms of the family's six-month FIA will have chosen a limited benefit plan in accordance with 441—Chapters 41 and 93.

h. Any family that is denied a hardship exemption may appeal the decision as described in 441—Chapter 7.

This rule is intended to implement Iowa Code chapter 239B.

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TITLE VIII
MEDICAL ASSISTANCECHAPTER 74
IOWA HEALTH AND WELLNESS PLAN

PREAMBLE

This chapter defines and structures the Iowa Health and Wellness Plan, effective January 1, 2014, and administered by the department pursuant to 2013 Iowa Acts, Senate File 446, sections 166 to 173 and 185 to 187. Implementation of the Iowa Health and Wellness Plan is subject to approval by the Secretary of the United States Department of Health and Human Services of any waivers of the requirements of Title XIX of the Social Security Act to provide for federal funding of the plan. This chapter shall be construed to comply with all requirements for federal funding under Title XIX of the Social Security Act or under the terms of any applicable waiver granted by the Secretary. To the extent this chapter is inconsistent with any applicable federal funding requirement under Title XIX or the terms of any applicable waiver, the requirements of Title XIX or the terms of the waiver shall prevail.

[ARC 1135C, IAB 10/30/13, effective 10/2/13]

441—74.1(249A,85GA,SF446) Definitions.

“Accountable care organization” means a risk-bearing, integrated health care organization characterized by a payment and care delivery model that ties provider reimbursement to quality metrics and reductions in the total cost of care for an attributed population of patients. An accountable care organization shall be qualified pursuant to rule 441—77.51(249A).

“Caretaker relative” means a relative listed in 441—subrule 75.55(1).

“Countable income” means “modified adjusted gross income” (MAGI) or “household income,” as applicable, determined pursuant to 42 U.S.C. § 1396a(e)(14).

“Department” means the Iowa department of human services.

“Enrollment period” means the 12-month period for which Iowa Health and Wellness plan eligibility is established.

“Essential health benefits” means the essential health benefits defined at 42 U.S.C. § 18022.

“Federal poverty level” means the poverty income guidelines revised annually and published in the Federal Register by the U.S. Department of Health and Human Services.

“Health insurance marketplace” or *“exchange”* means an American health benefit exchange established pursuant to 42 U.S.C. § 18031.

“Iowa Health and Wellness Plan” means the medical assistance program set forth in this chapter.

“Iowa wellness plan” means the benefits and services provided to Iowa Health and Wellness Plan members with countable income that does not exceed 100 percent of the federal poverty level.

“Marketplace choice plan” means the benefits and services provided to Iowa Health and Wellness Plan members with countable income between 101 percent and 133 percent of the federal poverty level.

“Medical home” means a provider contracted with the department through Form 470-5177, Agreement for Participation as a Patient Manager in the Iowa Health and Wellness Plan (Wellness Plan).

“Medically exempt individual” means an individual exempt from mandatory enrollment in an alternative benefit plan pursuant to 42 CFR § 440.315 as amended on July 15, 2013.

“Member” means an individual who is receiving assistance under the Iowa Health and Wellness Plan described in this chapter.

“Minimum essential coverage” means health insurance defined in Section 5000A(f) of Subtitle D of the Internal Revenue Code.

“Modified adjusted gross income” means the financial-eligibility methodology prescribed in 42 U.S.C. § 1396a(e)(14).

“Qualified employer-sponsored coverage” shall be defined pursuant to 42 U.S.C. § 1396e-1(b).

“Qualified health plan” shall be defined pursuant to Section 1301 of the Patient Protection and Affordable Care Act, Public Law 111-152.

[ARC 1135C, IAB 10/30/13, effective 10/2/13; ARC 1698C, IAB 10/29/14, effective 1/1/15]

441—74.2(249A,85GA,SF446) Eligibility factors. Except as more specifically provided in this chapter, Iowa Health and Wellness Plan eligibility shall be determined according to the requirements of 441—Chapter 75.

74.2(1) *Persons covered.* Subject to the additional requirements of this chapter and of 441—Chapter 75, medical assistance under the Iowa Health and Wellness Plan shall be available to persons 19 through 64 years of age who:

- a. Are not eligible for medical assistance in a mandatory group under 441—Chapter 75;
- b. Have countable income at or below 133 percent of the federal poverty level for their household size; and
- c. Are not entitled to or enrolled in Medicare benefits under Part A or Part B of Title XVIII of the Social Security Act; and
- d. Are not pregnant.

74.2(2) *Parents or caretakers of dependent children.* All children under the age of 21 living with a parent or other caretaker relative who will be claimed as a dependent by the parent or caretaker relative for state or federal income tax purposes must be enrolled in Medicaid, in the Children's Health Insurance Program (CHIP), or in other minimum essential coverage as a condition of the parent's or other caretaker relative's eligibility for Iowa Health and Wellness Plan benefits.

74.2(3) *Citizenship.* To be eligible for Iowa Health and Wellness Plan benefits, a person must meet the citizenship requirements in 441—Chapter 75.

[ARC 1135C, IAB 10/30/13, effective 10/2/13; ARC 1698C, IAB 10/29/14, effective 1/1/15]

441—74.3(249A,85GA,SF446) Application. Medicaid application policies and procedures described in 441—Chapter 76 shall apply to applications for the Iowa Health and Wellness Plan.

[ARC 1135C, IAB 10/30/13, effective 10/2/13]

441—74.4(249A,85GA,SF446) Financial eligibility.

74.4(1) *Countable income.* Individuals are financially eligible for the Iowa Health and Wellness Plan if their countable income is no more than 133 percent of the federal poverty level, as of the date of a decision on initial or ongoing eligibility.

74.4(2) *Household size.* For financial eligibility purposes, household size shall be determined according to the modified adjusted gross income (MAGI) methodology.

[ARC 1135C, IAB 10/30/13, effective 10/2/13]

441—74.5(249A,85GA,SF446) Enrollment period.

74.5(1) *Effective dates of eligibility.* Iowa Health and Wellness Plan eligibility shall be effective on the first day of the month of application or the first day of the month all eligibility requirements are met, whichever is later. The enrollment period shall continue for 12 consecutive months unless the member is disenrolled in accordance with the provisions of rule 441—74.8(249A,85GA,SF446).

74.5(2) *Retroactive enrollment.* Medical assistance shall be available for all or any of the three months preceding the month in which an application is filed in accordance with 441—subrule 76.13(2).

74.5(3) *Reinstatement.* Enrollment for the Iowa Health and Wellness Plan may be reinstated without a new application in accordance with 441—subrule 76.12(2).

74.5(4) *Presumptive eligibility.* The enrollment period of 12 consecutive months shall not apply to individuals temporarily enrolled in Medicaid based on a presumptive eligibility determination by a qualified entity in accordance with rules 441—76.7(249A) and 441—76.13(249A).

[ARC 1135C, IAB 10/30/13, effective 10/2/13; ARC 1698C, IAB 10/29/14, effective 1/1/15]

441—74.6(249A,85GA,SF446) Reporting changes.

74.6(1) *Reporting requirements.* As a condition of ongoing enrollment, a member shall report any of the following changes no later than ten calendar days after the change takes place:

- a. The member enters a nonmedical institution, including but not limited to a penal institution.
- b. The member abandons Iowa residency.
- c. The member turns 65.

- d. The member becomes entitled or enrolled in Medicare Part A or Part B or both.
- e. A child under the age of 21 living with the member loses minimum essential coverage, if the member is the child's parent or other caretaker relative and will claim the child as a dependent for state or federal income tax purposes.
- f. The member's countable income increases in a manner that must be reported according to the requirements of rule 441—76.15(249A).
- g. The member is confirmed pregnant.

74.6(2) *Untimely report.* When a change is not timely reported as required by this rule, any program expenditures for care or services provided when the member was not eligible shall be considered an overpayment and be subject to recovery from the member in accordance with rule 441—75.28(249A) and 441—Chapter 11. Program expenditures may include, but are not limited to, premiums and capitation payments.

74.6(3) *Effective date of change.* After enrollment, changes reported during the month that affect the member's eligibility shall be effective the first day of the next calendar month unless:

- a. Timely notice of adverse action is required as specified in 441—subrule 7.7(1); or
 - b. The enrollment period has expired and the member is not eligible for a new enrollment period.
- [ARC 1135C, IAB 10/30/13, effective 10/2/13; ARC 1698C, IAB 10/29/14, effective 1/1/15]

441—74.7(249A,85GA,SF446) *Reenrollment.* A new eligibility determination is required for consecutive 12-month enrollment periods. The reenrollment process will follow the requirements in 441—subrule 76.14(2).

[ARC 1135C, IAB 10/30/13, effective 10/2/13]

441—74.8(249A,85GA,SF446) *Terminating enrollment.* Iowa Health and Wellness Plan enrollment shall end when any of the following occurs:

- 1. The enrollment period ends and coverage for the next enrollment period has not been renewed.
- 2. The member becomes eligible for medical assistance in a mandatory coverage group under 441—Chapter 75.
- 3. The member is found to have been ineligible for any reason.
- 4. The member dies.
- 5. The member turns 65.
- 6. The member abandons Iowa residency.
- 7. The member becomes entitled or enrolled in Medicare Part A or Part B or both.
- 8. A child under the age of 21 living with the member loses minimum essential coverage, if the member is the child's parent or other caretaker relative and will claim the child as a dependent for state or federal income tax purposes.
- 9. The member's countable income exceeds 133 percent of the federal poverty level.
- 10. The member reports that she is pregnant.
- 11. The Iowa Health and Wellness Plan is discontinued according to the requirements in rule 441—74.14(249A,85GA,SF446).
- 12. The member does not pay monthly contributions as required by subrule 74.11(2).

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441—74.9(249A,85GA,SF446) *Recovery.* The department shall recover from a member all Medicaid funds incorrectly expended on behalf of the member in accordance with rule 441—75.28(249A).

74.9(1) The department shall recover Medicaid funds expended on behalf of a member from the member's estate in accordance with rule 441—75.28(249A).

74.9(2) Funds received from third parties, including Medicare, by a provider other than a state mental health institute shall be reported to the Iowa Medicaid enterprise, and an adjustment shall be made to a previously submitted claim.

[ARC 1135C, IAB 10/30/13, effective 10/2/13]

441—74.10(249A,85GA,SF446) Right to appeal.

74.10(1) Decisions and actions by the department regarding eligibility or services provided under this chapter may be appealed pursuant to 441—Chapter 7. A provider requesting a hearing on behalf of a member must have the prior express written consent of the member or the member's lawfully appointed guardian. Notwithstanding any contrary provision in 441—Chapter 7, no hearing will be granted unless the provider submits a document providing the member's consent to the request for a state fair hearing. The document must specifically inform the member that protected health information (PHI) may be discussed at the hearing and may be made public in the course of the hearing and subsequent administrative and judicial proceedings. The document must contain language that indicates the member's knowledge of the potential for PHI to become public and that the member knowingly, voluntarily, and intelligently consents to the provider's bringing the state fair hearing on the member's behalf.

74.10(2) Members will not be entitled to an appeal hearing if the sole basis for denying or limiting services is discontinuance of the program pursuant to rule 441—74.14(249A,85GA,SF446).

74.10(3) Coverage decisions and actions by participating marketplace choice plans must first be appealed through the plan's internal appeal process and through the external review process pursuant to Iowa Administrative Code 191—Chapter 76. After a member has exhausted the member's rights under the external review process, the member may appeal a decision or action pursuant to 441—Chapter 7. Appeal requests made pursuant to 441—Chapter 7 shall result in a change from benefits and service delivery under subrule 74.12(2) to benefits and service delivery under subrule 74.12(1). Benefits and service delivery under subrule 74.12(1) shall remain in effect for the remainder of the member's eligibility period.

[ARC 1135C, IAB 10/30/13, effective 10/2/13; ARC 1698C, IAB 10/29/14, effective 1/1/15]

441—74.11(249A,85GA,SF446) Financial participation.

74.11(1) Copayment. Payment for nonemergency use of a hospital emergency department shall be subject to an \$8 copayment by the member, which shall be subtracted from the Iowa Health and Wellness Plan payment otherwise due to the provider. This copayment will be waived during calendar year 2014.

74.11(2) Monthly contributions. Members enrolled in the Iowa Health and Wellness Plan with household income at or above 50 percent of the federal poverty level are required to pay monthly contributions pursuant to this rule.

a. Monthly contribution amount. The monthly contribution amount for each member is based on the countable income of the member's household, determined pursuant to rule 441—75.70(249A), as a percentage of the federal poverty level (FPL) for the household. Monthly contribution amounts are as follows:

- (1) For a member with household income between 50 and 100 percent of the FPL, \$5;
- (2) For a member with household income above 100 percent of the FPL, \$10.

b. Waiver during the first year of enrollment. The monthly contribution will be waived during the member's first 12 months of continuous enrollment.

c. Monthly contribution exemptions. A member shall be exempt from monthly contribution payments when any of the following circumstances apply:

- (1) The member completed healthy behaviors pursuant to subrule 74.11(4) in the previous enrollment period.
- (2) The member is determined to be a medically exempt individual pursuant to subrule 74.12(3).
- (3) The member has access to cost-effective, employer-sponsored coverage and is enrolled in the health insurance premium payment program pursuant to 441—Chapter 75.
- (4) The member is exempt from premiums pursuant to 42 CFR 447.56(a)(1)(x) as an Indian who is eligible to receive or has received an item or service furnished by an Indian health care provider or through referral under contract health services.

(5) The member claims a hardship exemption indicating that payment of the monthly contribution will be a financial hardship. The member may claim a hardship exemption by telephoning the call center designated by the department or by submitting a written statement to the address designated by

the department. The member's hardship exemption must be received or postmarked within five working days after the monthly contribution due date. If the hardship exemption request is not made in a timely manner, the exemption shall not be granted.

d. Billing and payment. Form 470-5285, Iowa Health and Wellness Plan Billing Statement, shall be used for billing and collection.

(1) Method of payment. Members shall submit contribution payments to the following address: Iowa Medicaid Enterprise, Iowa Health and Wellness Plan Monthly Contributions, P.O. Box 14485, Des Moines, Iowa 50306-3485.

(2) Due date. When the department notifies a member of the amount of the monthly contribution, the member shall pay any monthly contributions due in accordance with the following:

1. The monthly contribution for each month is due on the last calendar day of the month that the monthly contribution is to cover.

2. If the last calendar day falls on a weekend or state or federal holiday, payment is due on the first working day following the weekend or holiday.

3. Monthly contribution payments must be received or postmarked by the due date.

(3) Application of payment. The department shall apply monthly contributions payments received to the oldest unpaid month in the current enrollment period. When monthly contributions for all months in the enrollment period have been paid, the department shall hold any excess and apply it to any months for which eligibility is subsequently established.

e. Failure to pay monthly contributions.

(1) An Iowa wellness plan member who fails to pay the assessed monthly contributions and who does not qualify for a monthly contribution exemption pursuant to subrule 74.11(2) shall owe the monthly contribution to the department as an unpaid premium subject to recovery in accordance with rule 441—75.28(249A). A member shall have no less than 90 days from the due date to pay any unpaid monthly contribution before the unpaid amount shall be subject to recovery.

(2) A marketplace choice plan member who fails to pay the assessed monthly contribution and who does not qualify for a monthly contribution exemption pursuant to subrule 74.11(2) shall have the member's eligibility terminated. In addition, the unpaid monthly contribution shall be subject to recovery in accordance with rule 441—75.28(249A) as an unpaid premium.

1. A member shall have no less than 90 days from the due date to pay any unpaid monthly contribution before eligibility will be terminated or the unpaid amount will be subject to recovery.

2. A member whose eligibility is terminated due to nonpayment of monthly contributions must reenroll for Medicaid benefits pursuant to 441—Chapter 76.

f. Refund of monthly contributions.

(1) Monthly contributions paid for any period shall be refunded if the member qualified for a monthly contribution exemption pursuant to paragraph 74.11(2) "c" or when a member's Iowa Health and Wellness Plan coverage is terminated for the following reasons:

1. The member is no longer eligible for coverage in the Iowa Health and Wellness Plan; or

2. The member dies.

(2) The amount of any refund shall be offset by any outstanding monthly contributions owed.

(3) The refund shall be paid within two calendar months.

74.11(3) Aggregate annual limits on copayments and monthly contributions. The total aggregate annual amount of copayments and monthly contributions for an individual shall not exceed 5 percent of the household's countable annual income determined pursuant to rule 441—75.70(249A).

74.11(4) Healthy behaviors. An Iowa Health and Wellness Plan member who completes a wellness examination and health risk assessment during any enrollment year shall have monthly contributions waived in the subsequent enrollment year.

a. A wellness examination must be performed by a medical provider and must assess a member's overall physical health consistent with standard clinical guidelines for preventive physical examinations and as defined by the department.

b. A health risk assessment must be one of the following:

(1) An "Assess My Health" assessment offered through the department;

(2) An assessment offered by a managed care plan through which the member is receiving Iowa Health and Wellness Plan benefits; or

(3) An assessment offered by a qualified health plan through which the member is receiving Iowa Health and Wellness Plan benefits.

[ARC 1135C, IAB 10/30/13, effective 10/2/13; ARC 1698C, IAB 10/29/14, effective 1/1/15]

441—74.12(249A,85GA,SF446) Benefits and service delivery. Covered benefits and the service delivery method shall be determined by the member's countable income and health status.

74.12(1) Iowa wellness plan services. Iowa Health and Wellness Plan members with countable income that does not exceed 100 percent of the federal poverty level shall be enrolled in the Iowa wellness plan unless the member is determined by the department to be a medically exempt individual. The department shall provide the member with a medical assistance eligibility card identifying the member as eligible for Iowa wellness plan services.

a. Covered Iowa wellness plan services are essential health benefits, all other benefits required pursuant to 42 U.S.C. § 1396u-7(b)(1)(B), including prescription drugs, and dental services consistent with 441—Chapter 78.

b. The Iowa wellness plan provider network shall include all providers enrolled in the medical assistance program, including all participating accountable care organizations.

c. Members enrolled in the Iowa wellness plan shall be subject to enrollment in managed care, other than PACE programs, pursuant to 441—Chapter 88. In addition to reimbursement for managed care pursuant to 441—Chapter 88, the department may provide care coordination fees, performance incentive payments, or shared savings arrangements for medical homes and accountable care organizations serving members enrolled in the Iowa wellness plan.

d. When the member does not choose a primary medical provider, the department shall assign the member to a primary medical provider in accordance with the Medicaid managed health care mandatory enrollment provisions specified in 441—subrule 88.3(7) for mandatory enrollment counties and in accordance with quality data available to the department.

e. Dental services shall be provided through a contract with one or more commercial dental plans. The department may restrict member access to those entities with which the department contracts. The dental plan or plans shall provide the member with a dental card identifying the member as eligible for dental services.

74.12(2) Marketplace choice plan services. Iowa Health and Wellness Plan members with countable income between 101 percent and 133 percent of the federal poverty level shall be enrolled in a marketplace choice plan unless the member is determined by the department to be a medically exempt individual. Marketplace choice coverage shall be provided through designated qualified health plans available on the health insurance marketplace. Covered services not provided by the marketplace choice plan will be provided by the medical assistance program. Individuals who have been determined eligible for the marketplace choice plan, but who have not yet been enrolled in a marketplace choice plan, shall receive fee-for-service coverage under the Iowa wellness plan until they choose or are assigned to a marketplace choice plan.

a. Upon enrollment, a member shall choose a qualified health plan from those designated by the department to provide coverage to marketplace choice plan members.

b. When the member does not select a qualified health plan pursuant to notice of the need to do so, the department will select a plan, enroll the member, and notify the member of the assigned plan.

c. The department shall pay premiums to designated qualified health plans participating on the health insurance marketplace to buy coverage for eligible marketplace choice plan members. The department shall begin payment of the member's premiums for the first month of enrollment in the qualified health plan. The qualified health plan shall provide the member with an insurance card identifying the member as an enrollee of the plan. The department shall provide the member with a medical assistance eligibility card for covered medical services not provided by the qualified health plan.

d. Covered services are all benefits, including essential health benefits, provided by the designated qualified health plan on the health insurance marketplace, including prescription drugs. Services not covered by the qualified health plan, but covered pursuant to the marketplace choice 1115 waiver or the marketplace choice state plan will be covered by the Medicaid program.

e. Dental services shall be provided through a contract with one or more commercial dental plans with covered services consistent with 441—Chapter 78. The department may restrict member access to those entities with which the department contracts. The dental plan or plans shall provide the member with a dental card identifying the member as eligible for dental services.

74.12(3) *Medically exempt individuals.* An Iowa Health and Wellness Plan member who has been determined by the department to be a medically exempt individual shall be given the choice of the benefits and service delivery method provided by the Iowa wellness plan or receiving benefits and services pursuant to 441—Chapter 78.

a. A member may attest to being a medically exempt individual by submitting a completed Form 470-5194.

b. A provider with a current National Provider Identifier number, an employee of the department of human services, a designee of the department of corrections, a qualified health plan, or a mental health and disability services region established pursuant to Iowa Code sections 331.388 to 331.399 may refer a member for a medically exempt individual determination by submitting a completed Form 470-5196, Medically Exempt Attestation and Referral Form.

c. Upon receipt of Form 470-5194 or 470-5196, the Iowa Medicaid enterprise shall determine whether the member qualifies as a medically exempt individual in accordance with 42 CFR § 440.315 as amended on July 15, 2013.

74.12(4) *Qualified employer-sponsored coverage.* An individual who has access to cost-effective employer-sponsored coverage shall be subject to enrollment in the health insurance premium payment program pursuant to 441—Chapter 75.

[ARC 1135C, IAB 10/30/13, effective 10/2/13; ARC 1698C, IAB 10/29/14, effective 1/1/15]

441—74.13(249A,85GA,SF446) Claims and reimbursement methodologies.

74.13(1) *Claims for services not provided by a qualified health plan.* Claims for services provided under the Iowa wellness plan or for covered marketplace choice services not provided by the member's qualified health plan shall be submitted to the Iowa Medicaid enterprise as required by 441—Chapter 80.

74.13(2) *Payment for services not provided by a qualified health plan.* Payment for services provided under the Iowa wellness plan or for covered marketplace choice services not provided by the member's qualified health plan shall be provided in accordance with 441—Chapter 79 or as provided in a contract between the department and the provider.

74.13(3) *Payment for services provided by the marketplace choice plan.* Payment for services provided under the marketplace choice plan shall be made in accordance with the rates filed with the Iowa insurance division.

[ARC 1135C, IAB 10/30/13, effective 10/2/13]

441—74.14(249A,85GA,SF446) Discontinuance of program.

74.14(1) If the methodology for calculating the federal medical assistance percentage for eligible individuals, as provided in 42 U.S.C. § 1396d(y), is modified through federal law or regulation, in a manner that reduces the percentage of federal assistance to the state, or if federal law or regulation affecting eligibility or benefits for the Iowa Health and Wellness Plan is modified, the department may implement an alternative plan as specified in the medical assistance state plan or waiver for coverage of the affected population, subject to prior, statutory approval of implementation of the alternative plan.

74.14(2) If the methodology for calculating the federal medical assistance percentage for eligible individuals, as provided in 42 U.S.C. § 1396d(y), is modified through federal law or regulation resulting in a reduction of the percentage of federal assistance to the state below 90 percent but not below 85 percent, the medical assistance program reimbursement rates for inpatient and outpatient hospital

services shall be reduced by a like percentage in the succeeding fiscal year, subject to prior, statutory approval of implementation of the reduction.

[ARC 1135C, IAB 10/30/13, effective 10/2/13]

441—74.15(249A,85GA,ch138) Enrollment for IowaCare members.

74.15(1) Subject to a waiver of the eligibility requirements of 42 U.S.C. § 1396a(e)(14)(A) by the federal Centers for Medicare and Medicaid Services, and notwithstanding any other provision of this chapter, an individual who is enrolled in the IowaCare program under 441—Chapter 92 on October 1, 2013, shall be enrolled without an application in the Iowa Health and Wellness Plan effective January 1, 2014, if department records show:

a. That the income of all household members considered in determining the individual's eligibility for IowaCare (other than child support income) does not exceed 138 percent of the federal poverty level for a household of that size, based on the following sources of income information, in the following order of priority:

(1) Income used to determine eligibility for food assistance for the individual and other IowaCare household members, pursuant to 441—Chapter 92;

(2) Income used to determine eligibility for medical assistance for other IowaCare household members, pursuant to 441—Chapter 75;

(3) Iowa workforce development unemployment insurance benefit data available to the department pursuant to 441—paragraph 9.10(4) “c”;

(4) Iowa workforce development wage data available to the department pursuant to 441—paragraph 9.10(4) “c”;

(5) Income and eligibility verification system data available to the department pursuant to 441—paragraph 9.10(4) “c”; and

b. That the individual meets all eligibility requirements of the Iowa Health and Wellness Plan, pursuant to this chapter, other than income.

74.15(2) Individuals enrolled pursuant to this rule will thereafter be subject to all the provisions of this chapter, with no further application of this rule.

[ARC 1214C, IAB 12/11/13, effective 11/13/13; ARC 1354C, IAB 3/5/14, effective 4/9/14]

These rules are intended to implement 2013 Iowa Acts, Senate File 446, sections 166 to 173 and 185 to 187, and Iowa Code chapter 249A.

[Filed Emergency After Notice ARC 1135C (Notice ARC 0972C, IAB 8/21/13), IAB 10/30/13, effective 10/2/13]

[Filed Emergency ARC 1214C, IAB 12/11/13, effective 11/13/13]

[Filed ARC 1354C (Notice ARC 1213C, IAB 12/11/13), IAB 3/5/14, effective 4/9/14]

[Filed ARC 1698C (Notice ARC 1618C, IAB 9/3/14), IAB 10/29/14, effective 1/1/15]

CHAPTER 77
CONDITIONS OF PARTICIPATION FOR PROVIDERS
OF MEDICAL AND REMEDIAL CARE

[Prior to 7/1/83, Social Services[770] Ch 77]

[Prior to 2/11/87, Human Services[498]]

441—77.1(249A) Physicians. All physicians (doctors of medicine and osteopathy) licensed to practice in the state of Iowa are eligible to participate in the program. Physicians in other states are also eligible if duly licensed to practice in that state.

441—77.2(249A) Retail pharmacies. Retail pharmacies are eligible to participate if they meet the requirements of this rule.

77.2(1) *Licensure.* Participating retail pharmacies must be licensed in the state of Iowa or duly licensed in another state. Out-of-state retail pharmacies delivering, dispensing, or distributing drugs by any method to an ultimate user physically located in Iowa must be duly licensed by Iowa as a nonresident pharmacy for that purpose.

77.2(2) *Survey participation.* As a condition of participation, retail pharmacies are required to make available drug acquisition cost invoice information, product availability information if known, dispensing cost information, and any other information deemed necessary by the department to assist in monitoring and revising reimbursement rates pursuant to 441—subrule 79.1(8) or for the efficient operation of the pharmacy benefit.

a. A pharmacy shall produce and submit all requested information in the manner and format requested by the department or its designee at no cost to the department or its designee.

b. A pharmacy shall submit information to the department or its designee within the time frame indicated following receipt of a request for information unless the department or its designee grants an extension upon written request of the pharmacy.

c. Any dispensing or acquisition cost information submitted to the department that specifically identifies a pharmacy's individual costs shall be held confidential.

[ARC 0485C, IAB 12/12/12, effective 2/1/13]

441—77.3(249A) Hospitals.

77.3(1) *Qualifications.* All hospitals licensed in the state of Iowa or in another state and certified as eligible to participate in Part A of the Medicare program (Title XVIII of the Social Security Act) are eligible to participate in the medical assistance program, subject to the additional requirements of this rule.

77.3(2) *Referral to health home services provider.* As a condition of participation in the medical assistance program, hospitals must establish procedures for referring to health home services providers any members who seek or need treatment in the hospital emergency department and who are eligible for health home services pursuant to 441—subrule 78.53(2).

This rule is intended to implement Iowa Code section 249A.4.

[ARC 0198C, IAB 7/11/12, effective 7/1/12]

441—77.4(249A) Dentists. All dentists licensed to practice in the state of Iowa are eligible to participate in the program. Dentists in other states are also eligible if duly licensed to practice in that state.

NOTE: DENTAL LABORATORIES—Payment will not be made to a dental laboratory.

441—77.5(249A) Podiatrists. All podiatrists licensed to practice in the state of Iowa are eligible to participate in the program. Podiatrists in other states are also eligible if duly licensed to practice in that state.

441—77.6(249A) Optometrists. All optometrists licensed to practice in the state of Iowa are eligible to participate in the program. Optometrists in other states are also eligible if duly licensed to practice in that state.

441—77.7(249A) Opticians. All opticians in the state of Iowa are eligible to participate in the program. Opticians in other states are also eligible to participate.

NOTE: Opticians in states having licensing requirements for this professional group must be duly licensed in that state.

441—77.8(249A) Chiropractors. All chiropractors licensed to practice in the state of Iowa are eligible to participate providing they have been determined eligible to participate in Title XVIII of the Social Security Act (Medicare) by the Social Security Administration. Chiropractors in other states are also eligible if duly licensed to practice in that state and determined eligible to participate in Title XVIII of the Social Security Act.

441—77.9(249A) Home health agencies. Home health agencies are eligible to participate providing they are certified to participate in the Medicare program (Title XVIII of the Social Security Act) and, unless exempted under subrule 77.9(5), have submitted a surety bond as required by subrules 77.9(1) to 77.9(6).

77.9(1) Definitions.

“Assets” includes any listing that identifies Medicaid members to whom home health services were furnished by a participating or formerly participating home health agency.

“Rider” means a notice issued by a surety that a change in the bond has occurred or will occur.

“Uncollected overpayment” means a Medicaid overpayment, including accrued interest, for which the home health agency is responsible that has not been recouped by the department within 60 days from the date of notification that an overpayment has been identified.

77.9(2) Parties to surety bonds. The surety bond shall name the home health agency as the principal, the Iowa department of human services as the obligee and the surety company (and its heirs, executors, administrators, successors and assignees, jointly and severally) as surety. The bond shall be issued by a company holding a current Certificate of Authority issued by the U.S. Department of the Treasury in accordance with 31 U.S.C. Sections 9304 to 9308 and 31 CFR Part 223 as amended to November 30, 1984, Part 224 as amended to May 29, 1996, and Part 225 as amended to September 12, 1974. The bond shall list the surety’s name, street address or post office box number, city, state and ZIP code. The company shall not have been determined by the department to be unauthorized in Iowa due to:

a. Failure to furnish timely confirmation of the issuance of and the validity and accuracy of information appearing on a surety bond that a home health agency presents to the department that shows the surety company as surety on the bond.

b. Failure to timely pay the department in full the amount requested, up to the face amount of the bond, upon presentation by the department to the surety company of a request for payment on a surety bond and of sufficient evidence to establish the surety company’s liability on the bond.

c. Other good cause.

The department shall give public notice of a determination that a surety company is unauthorized in Iowa and the effective date of the determination by publication of a notice in the newspaper of widest circulation in each city in Iowa with a population of 50,000 or more. A list of surety companies determined by the department to be unauthorized in Iowa shall be maintained and shall be available for public inspection by contacting the division of medical services of the department. The determination that a surety company is unauthorized in Iowa has effect only in Iowa and is not a debarment, suspension, or exclusion for the purposes of Federal Executive Order No. 12549.

77.9(3) Surety company obligations. The bond shall guarantee payment to the department, up to the face amount of the bond, of the full amount of any uncollected overpayment, including accrued interest, based on payments made to the home health agency during the term of the bond. The bond shall provide that payment may be demanded from the surety after available administrative collection methods for collecting from the home health agency have been exhausted.

77.9(4) Surety bond requirements. Surety bonds secured by home health agencies participating in Medicaid shall comply with the following requirements:

a. *Effective dates and submission dates.*

(1) Home health agencies participating in the program on June 10, 1998, shall secure either an initial surety bond for the period January 1, 1998, through the end of the home health agency's fiscal year or a continuous bond which remains in effect from year to year.

(2) Home health agencies seeking to participate in Medicaid and Medicare for the first time after June 10, 1998, shall secure an initial surety bond for the period from Medicaid certification through the end of the home health agency's fiscal year or a continuous bond which remains in effect from year to year.

(3) Medicare-certified home health agencies seeking to participate in Medicaid for the first time after June 10, 1998, shall secure an initial surety bond for the period from Medicaid certification through the end of the home health agency's fiscal year or a continuous bond which remains in effect from year to year.

(4) Home health agencies seeking to participate in Medicaid after purchasing the assets of or an ownership interest in a participating or formerly participating agency shall secure an initial surety bond effective as of the date of purchase of the assets or the transfer of the ownership interest for the balance of the current fiscal year of the home health agency or a continuous bond which remains in effect from year to year.

(5) Home health agencies which continue to participate in Medicaid after the period covered by an initial surety bond shall secure a surety bond for each subsequent fiscal year of the home health agency or a continuous bond which remains in effect from year to year.

b. Amount of bond. Bonds for any period shall be in the amount of \$50,000 or 15 percent of the home health agency's annual Medicaid payments during the most recently completed state fiscal year, whichever is greater. After June 1, 2005, all bonds shall be in the amount of \$50,000. At least 90 days before the start of each home health agency's fiscal year, the department shall provide notice of the amount of the surety bond to be purchased and submitted to the Iowa Medicaid enterprise provider services unit.

c. Other requirements. Surety bonds shall meet the following additional requirements. The bond shall:

(1) Guarantee that upon written demand by the department to the surety for payment under the bond and the department's furnishing to the surety sufficient evidence to establish the surety's liability under the bond, the surety shall within 60 days pay the department the amount so demanded, up to the stated amount of the bond.

(2) Provide that the surety's liability for uncollected overpayments is based on overpayments determined during the term of the bond.

(3) Provide that the surety's liability to the department is not extinguished by any of the following:

1. Any action by the home health agency or the surety to terminate or limit the scope or term of the bond unless the surety furnishes the department with notice of the action not later than 10 days after the date of notice of the action by the home health agency to the surety and not later than 60 days before the effective date of the action by the surety.

2. The surety's failure to continue to meet the requirements in subrule 77.9(2) or the department's determination that the surety company is an unauthorized surety under subrule 77.9(2).

3. Termination of the home health agency's provider agreement.

4. Any action by the department to suspend, offset, or otherwise recover payments to the home health agency.

5. Any action by the home health agency to cease operations, sell or transfer any assets or ownership interest, file for bankruptcy, or fail to pay the surety.

6. Any fraud, misrepresentation, or negligence by the home health agency in obtaining the surety bond or by the surety (or the surety's agent, if any) in issuing the surety bond; except that any fraud, misrepresentation, or negligence by the home health agency in identifying to the surety (or the surety's agent) the amount of Medicaid payments upon which the amount of the surety bond is determined shall not cause the surety's liability to the department to exceed the amount of the bond.

7. The home health agency's failure to exercise available appeal rights under Medicaid or assign appeal rights to the surety.

(4) Provide that if a home health agency fails to furnish a bond following the expiration date of an annual bond or if a home health agency fails to furnish a rider for a year in which a rider is required or if the home health agency's provider agreement with the department is terminated, the surety shall remain liable under the most recent annual bond or rider to a continuous bond for two years from the date the home health agency was required to submit the annual bond or rider to a continuous bond or for two years from the termination date of the provider agreement.

(5) Provide that actions under the bond may be brought by the department or by an agent designated by the department.

(6) Provide that the surety may appeal department decisions.

77.9(5) *Exemption from surety bond requirements for government-operated home health agencies.* A home health agency operated by a federal, state, local, or tribal government agency is exempt from the bonding requirements of this rule if, during the preceding five years, the home health agency has not had any uncollected overpayments. Government-operated home health agencies having uncollected overpayments during the preceding five years shall not be exempted from the bonding requirements of this rule.

77.9(6) *Government-operated home health agency that loses its exemption.* A government-operated home health agency which has met the criteria for an exemption under subrule 77.9(6) but is later determined by the department not to meet the criteria shall submit a surety bond within 60 days of the date of the department's written notification to the home health agency that it no longer meets the criteria for an exemption, for the period and in the amount required in the notice from the department.

441—77.10(249A) Medical equipment and appliances, prosthetic devices and medical supplies. All dealers in medical equipment and appliances, prosthetic devices and medical supplies in Iowa or in other states are eligible to participate in the program.

441—77.11(249A) Ambulance service. Providers of ambulance service are eligible to participate providing they meet the eligibility requirements for participation in the Medicare program (Title XVIII of the Social Security Act).

441—77.12(249A) Behavioral health intervention. A provider of behavioral health intervention is eligible to participate in the medical assistance program when the provider is enrolled in the Iowa Plan for Behavioral Health pursuant to 441—Chapter 88, Division IV. Providers must complete child abuse, dependent adult abuse, and criminal background screenings pursuant to Iowa Code section 135C.33(5)“a”(1) before employment of a staff member who will provide direct care.

This rule is intended to implement Iowa Code section 249A.4 and 2010 Iowa Acts, chapter 1192, section 31.

[ARC 7741B, IAB 5/6/09, effective 7/1/09; ARC 9487B, IAB 5/4/11, effective 7/1/11]

441—77.13(249A) Hearing aid dispensers. Hearing aid dispensers are eligible to participate if they are duly licensed by the state of Iowa. Hearing aid dispensers in other states will be eligible to participate if they are duly licensed in that state.

This rule is intended to implement Iowa Code section 249A.4.

441—77.14(249A) Audiologists. Audiologists are eligible to participate in the program when they are duly licensed by the state of Iowa. Audiologists in other states will be eligible to participate when they are duly licensed in that state. In states having no licensure requirement for audiologists, an audiologist shall obtain a license from the state of Iowa.

This rule is intended to implement Iowa Code section 249A.4.

441—77.15(249A) Community mental health centers. Community mental health centers are eligible to participate in the medical assistance program when they comply with the standards for mental health centers in the state of Iowa established by the Iowa mental health authority.

This rule is intended to implement Iowa Code section 249A.4.

441—77.16(249A) Screening centers. Public or private health agencies are eligible to participate as screening centers when they have the staff and facilities needed to perform all of the elements of screening specified in 441—78.18(249A) and meet the department of public health's standards for a child health screening center. The staff members must be employed by or under contract with the screening center. Screening centers shall direct applications to participate to the Iowa Medicaid enterprise provider services unit.

This rule is intended to implement Iowa Code section 249A.4.

441—77.17(249A) Physical therapists. Physical therapists are eligible to participate when they are licensed, in independent practice; and are eligible to participate in the Medicare program.

This rule is intended to implement Iowa Code section 249A.4.

441—77.18(249A) Orthopedic shoe dealers and repair shops. Establishments eligible to participate in the medical assistance program are retail dealers in orthopedic shoes prescribed by physicians or podiatrists and shoe repair shops specializing in orthopedic work as prescribed by physicians or podiatrists.

This rule is intended to implement Iowa Code section 249A.4.

441—77.19(249A) Rehabilitation agencies. Rehabilitation agencies are eligible to participate providing they are certified to participate in the Medicare program (Title XVIII of the Social Security Act).

This rule is intended to implement Iowa Code section 249A.4.

441—77.20(249A) Independent laboratories. Independent laboratories are eligible to participate providing they are certified to participate as a laboratory in the Medicare program (Title XVIII of the Social Security Act). An independent laboratory is a laboratory that is independent of attending and consulting physicians' offices, hospitals, and critical access hospitals.

This rule is intended to implement Iowa Code section 249A.4.

441—77.21(249A) Rural health clinics. Rural health clinics are eligible to participate providing they are certified to participate in the Medicare program (Title XVIII of the Social Security Act).

441—77.22(249A) Psychologists. All psychologists licensed to practice in the state of Iowa and meeting the standards of the National Register of Health Service Providers in Psychology, 1981 edition, published by the council for the National Register of Health Service Providers in Psychology, are eligible to participate in the medical assistance program. Psychologists in other states are eligible to participate when they are duly licensed to practice in that state and meet the standards of the National Register of Health Service Providers in Psychology.

This rule is intended to implement Iowa Code sections 249A.4 and 249A.15.

441—77.23(249A) Maternal health centers. A maternal health center is eligible to participate in the Medicaid program if the center provides a team of professionals to render prenatal and postpartum care and enhanced perinatal services (see rule 441—78.25(249A)). The prenatal and postpartum care shall be in accordance with the latest edition of the American College of Obstetricians and Gynecologists, Standards for Obstetric Gynecologic Services. The team must have at least a physician, a registered nurse, a licensed dietitian and a person with at least a bachelor's degree in social work, counseling, sociology or psychology. Team members must be employed by or under contract with the center.

This rule is intended to implement Iowa Code section 249A.4.

441—77.24(249A) Ambulatory surgical centers. Ambulatory surgical centers that are not part of hospitals are eligible to participate in the medical assistance program if they are certified to participate in the Medicare program (Title XVIII of the Social Security Act). Freestanding ambulatory surgical centers providing only dental services are also eligible to participate in the medical assistance program

if the board of dental examiners has issued a current permit pursuant to 650—Chapter 29 for any dentist to administer deep sedation or general anesthesia at the facility.

441—77.25(249A) Home- and community-based habilitation services. To be eligible to participate in the Medicaid program as an approved provider of home- and community-based habilitation services, a provider shall be an enrolled provider of habilitation with the Iowa Plan for Behavioral Health and meet the general requirements in subrules 77.25(2), 77.25(3), and 77.25(4) and shall meet the requirements in the subrules applicable to the individual services being provided.

77.25(1) Definitions.

“Guardian” means a guardian appointed in probate or juvenile court.

“Major incident” means an occurrence involving a member during service provision that:

1. Results in a physical injury to or by the member that requires a physician’s treatment or admission to a hospital;
2. Results in the death of any person;
3. Requires emergency mental health treatment for the member;
4. Requires the intervention of law enforcement;
5. Requires a report of child abuse pursuant to Iowa Code section 232.69 or a report of dependent adult abuse pursuant to Iowa Code section 235B.3;
6. Constitutes a prescription medication error or a pattern of medication errors that leads to the outcome in paragraph “1,” “2,” or “3”; or
7. Involves a member’s location being unknown by provider staff who are assigned protective oversight.

“Member” means a person who has been determined to be eligible for Medicaid under 441—Chapter 75.

“Minor incident” means an occurrence involving a member during service provision that is not a major incident and that:

1. Results in the application of basic first aid;
2. Results in bruising;
3. Results in seizure activity;
4. Results in injury to self, to others, or to property; or
5. Constitutes a prescription medication error.

77.25(2) Organization and staff.

a. The prospective provider shall demonstrate the fiscal capacity to initiate and operate the specified programs on an ongoing basis.

b. The provider shall complete child abuse, dependent adult abuse, and criminal background screenings pursuant to Iowa Code section 249A.29 before employing a person who will provide direct care.

c. A person providing direct care shall be at least 16 years of age.

d. A person providing direct care shall not be an immediate family member of the member.

77.25(3) Incident management and reporting. As a condition of participation in the medical assistance program, HCBS habilitation service providers must comply with the requirements of Iowa Code sections 232.69 and 235B.3 regarding the reporting of child abuse and dependent adult abuse and with the incident management and reporting requirements in this subrule.

a. *Reporting procedure for minor incidents.* Minor incidents may be reported in any format designated by the provider. When a minor incident occurs or a staff member becomes aware of a minor incident, the staff member involved shall submit the completed incident report to the staff member’s supervisor within 72 hours of the incident. The completed report shall be maintained in a centralized file with a notation in the member’s file.

b. *Reporting procedure for major incidents.* When a major incident occurs or a staff member becomes aware of a major incident:

(1) The staff member involved shall notify the following persons of the incident by the end of the next calendar day after the incident:

1. The staff member's supervisor.
2. The member or the member's legal guardian. EXCEPTION: Notification to the member is required only if the incident took place outside of the provider's service provision. Notification to the guardian, if any, is always required.

3. The member's case manager.

(2) By the end of the next calendar day after the incident, the staff member who observed or first became aware of the incident shall also report as much information as is known about the incident to the department's bureau of long-term care either:

1. By direct data entry into the Iowa Medicaid Provider Access System, or
2. By faxing or mailing Form 470-4698, Critical Incident Report, according to the directions on the form.

(3) The following information shall be reported:

1. The name of the member involved.
2. The date and time the incident occurred.
3. A description of the incident.
4. The names of all provider staff and others who were present at the time of the incident or who responded after becoming aware of the incident. The confidentiality of other members or nonmembers who were present must be maintained by the use of initials or other means.
5. The action that the provider staff took to manage the incident.
6. The resolution of or follow-up to the incident.
7. The date the report is made and the handwritten or electronic signature of the person making the report.

(4) Submission of the initial report will generate a workflow in the Individualized Services Information System (ISIS) for follow-up by the case manager. When complete information about the incident is not available at the time of the initial report, the provider must submit follow-up reports until the case manager is satisfied with the incident resolution and follow-up. The completed report shall be maintained in a centralized file with a notation in the member's file.

c. Tracking and analysis. The provider shall track incident data and analyze trends to assess the health and safety of members served and determine if changes need to be made for service implementation or if staff training is needed to reduce the number or severity of incidents.

77.25(4) Restraint, restriction, and behavioral intervention. The provider shall have in place a system for the review, approval, and implementation of ethical, safe, humane, and efficient behavioral intervention procedures. All members receiving home- and community-based habilitation services shall be afforded the protections imposed by these rules when any restraint, restriction, or behavioral intervention is implemented.

a. The system shall include procedures to inform the member and the member's legal guardian of the restraint, restriction, and behavioral intervention policy and procedures at the time of service approval and as changes occur.

b. Restraint, restriction, and behavioral intervention shall be used only for reducing or eliminating maladaptive target behaviors that are identified in the member's restraint, restriction, or behavioral intervention program.

c. Restraint, restriction, and behavioral intervention procedures shall be designed and implemented only for the benefit of the member and shall never be used as punishment, for the convenience of the staff, or as a substitute for a nonaversive program.

d. Restraint, restriction, and behavioral intervention programs shall be time-limited and shall be reviewed at least quarterly.

e. Corporal punishment and verbal or physical abuse are prohibited.

77.25(5) Case management. The department of human services, a county or consortium of counties, or a provider under subcontract to the department or to a county or consortium of counties is eligible to participate in the home- and community-based habilitation services program as a provider of case management services provided that the agency meets the standards in 441—Chapter 24.

77.25(6) Day habilitation. The following providers may provide day habilitation:

a. An agency that is accredited by the Commission on Accreditation of Rehabilitation Facilities to provide services that qualify as day habilitation under 441—subrule 78.27(8).

b. An agency that is accredited by the Commission on Accreditation of Rehabilitation Facilities to provide other services and began providing services that qualify as day habilitation under 441—subrule 78.27(8) since the agency's last accreditation survey. The agency may provide day habilitation services until the current accreditation expires. When the current accreditation expires, the agency must qualify under paragraph "*a*," "*d*," "*g*," or "*h*."

c. An agency that is not accredited by the Commission on Accreditation of Rehabilitation Facilities but has applied to the Commission within the last 12 months for accreditation to provide services that qualify as day habilitation under 441—subrule 78.27(8). An agency that has not received accreditation within 12 months after application to the Commission is no longer a qualified provider.

d. An agency that is accredited by the Council on Quality and Leadership in Supports for People with Disabilities.

e. An agency that has applied to the Council on Quality and Leadership in Supports for People with Disabilities for accreditation within the last 12 months. An agency that has not received accreditation within 12 months after application to the Council is no longer a qualified provider.

f. An agency that is accredited under 441—Chapter 24 to provide day treatment or supported community living services.

g. An agency that is certified by the department to provide day habilitation services under the home- and community-based services intellectual disability waiver pursuant to rule 441—77.37(249A).

h. An agency that is accredited by the International Center for Clubhouse Development.

i. An agency that is accredited by the Joint Commission on Accreditation of Healthcare Organizations.

j. A residential care facility of more than 16 beds that is licensed by the Iowa department of inspections and appeals, was enrolled as a provider of rehabilitation services for adults with chronic mental illness before December 31, 2006, and has applied for accreditation through one of the accrediting bodies listed in this subrule.

(1) The facility must have policies in place by June 30, 2007, consistent with the accreditation being sought.

(2) A facility that has not received accreditation within 12 months after application for accreditation is no longer a qualified provider.

77.25(7) *Home-based habilitation.* The following agencies may provide home-based habilitation services:

a. An agency that is certified by the department to provide supported community living services under:

(1) The home- and community-based services intellectual disability waiver pursuant to rule 441—77.37(249A); or

(2) The home- and community-based services brain injury waiver pursuant to rule 441—77.39(249A).

b. An agency that is accredited under 441—Chapter 24 to provide supported community living services.

c. An agency that is accredited by the Commission on Accreditation of Rehabilitation Facilities as a community housing or supported living service provider.

d. An agency that is accredited by the Council on Quality and Leadership in Supports for People with Disabilities.

e. An agency that is accredited by the Council on Accreditation of Services for Families and Children.

f. An agency that is accredited by the Joint Commission on Accreditation of Healthcare Organizations.

g. A residential care facility of 16 or fewer beds that is licensed by the Iowa department of inspections and appeals, was enrolled as a provider of rehabilitation services for adults with chronic

mental illness before December 31, 2006, and has applied for accreditation through one of the accrediting bodies listed in this subrule.

(1) The facility must have policies in place by June 30, 2007, consistent with the accreditation being sought.

(2) A facility that has not received accreditation within 12 months after application for accreditation is no longer a qualified provider.

77.25(8) *Prevocational habilitation.* The following providers may provide prevocational services:

a. An agency that is accredited by the Commission on Accreditation of Rehabilitation Facilities as an organizational employment service provider or a community employment service provider.

b. An agency that is accredited by the Council on Quality and Leadership in Supports for People with Disabilities.

c. An agency that is accredited by the International Center for Clubhouse Development.

d. An agency that is certified by the department to provide prevocational services under:

(1) The home- and community-based services intellectual disability waiver pursuant to rule 441—77.37(249A); or

(2) The home- and community-based services brain injury waiver pursuant to rule 441—77.39(249A).

77.25(9) *Supported employment habilitation.* The following agencies may provide supported employment services:

a. An agency that is certified by the department to provide supported employment services under:

(1) The home- and community-based services intellectual disability waiver pursuant to rule 441—77.37(249A); or

(2) The home- and community-based services brain injury waiver pursuant to rule 441—77.39(249A).

b. An agency that is accredited by the Commission on Accreditation of Rehabilitation Facilities as an organizational employment service provider or a community employment service provider.

c. An agency that is accredited by the Council on Accreditation of Services for Families and Children.

d. An agency that is accredited by the Joint Commission on Accreditation of Healthcare Organizations.

e. An agency that is accredited by the Council on Quality and Leadership in Supports for People with Disabilities.

f. An agency that is accredited by the International Center for Clubhouse Development.

77.25(10) *Provider enrollment.* A prospective provider that meets the criteria in this rule and the provider criteria of the Iowa Plan for Behavioral Health contractor must be enrolled through the Iowa Plan for Behavioral Health contractor as an approved provider of a specific component of home- and community-based habilitation services. Enrollment carries no assurance that the approved provider will receive funding. The Iowa Medicaid enterprise will enroll providers with Medicaid only when the provider is enrolled in the Iowa Plan for Behavioral Health. Payment for services will be made to a provider only when the provider is enrolled in the Iowa Plan for Behavioral Health and the provider is authorized to provide the services. This includes payments made by the Iowa Medicaid enterprise for services provided to members who are not eligible to enroll in the Iowa Plan for Behavioral Health.

a. The Iowa Plan for Behavioral Health contractor shall review compliance with standards for initial enrollment. Review of a provider may occur at any time.

b. The department or the Iowa Plan for Behavioral Health contractor may request any information from the prospective service provider that is pertinent to arriving at an enrollment decision. This information may include:

(1) Current accreditations.

(2) Evaluations.

(3) Inspection reports.

(4) Reviews by regulatory and licensing agencies and associations.

This rule is intended to implement Iowa Code section 249A.4.

[ARC 7936B, IAB 7/1/09, effective 9/1/09; ARC 9314B, IAB 12/29/10, effective 3/1/11; ARC 0848C, IAB 7/24/13, effective 7/1/13; ARC 1051C, IAB 10/2/13, effective 11/6/13]

441—77.26(249A) Behavioral health services. The following persons are eligible to participate in the Medicaid program as providers of behavioral health services.

77.26(1) Licensed marital and family therapists (LMFT). Any person licensed by the board of behavioral science as a marital and family therapist pursuant to 645—Chapter 31 is eligible to participate. A marital and family therapist in another state is eligible to participate when duly licensed to practice in that state.

77.26(2) Licensed independent social workers (LISW). Any person licensed by the board of social work as an independent social worker pursuant to 645—Chapter 280 is eligible to participate. An independent social worker in another state is eligible to participate when duly licensed to practice in that state.

77.26(3) Licensed master social workers (LMSW).

a. A person licensed by the board of social work as a master social worker pursuant to 645—Chapter 280 is eligible to participate when the person:

- (1) Holds a master's or doctoral degree as approved by the board of social work; and
- (2) Provides treatment under the supervision of an independent social worker licensed pursuant to 645—Chapter 280.

b. A master social worker in another state is eligible to participate when the person:

- (1) Is duly licensed to practice in that state; and
- (2) Provides treatment under the supervision of an independent social worker duly licensed in that state.

77.26(4) Licensed mental health counselors (LMC). Any person licensed by the board of behavioral science as a mental health counselor pursuant to Iowa Code chapter 154D and 645—Chapter 31 is eligible to participate. A mental health counselor in another state is eligible to participate when duly licensed to practice in that state.

77.26(5) Certified alcohol and drug counselors. Any person certified by the nongovernmental Iowa board of substance abuse certification as an alcohol and drug counselor is eligible to participate.

This rule is intended to implement Iowa Code chapter 249A as amended by 2011 Iowa Acts, Senate File 233.

[ARC 9649B, IAB 8/10/11, effective 8/1/11]

441—77.27(249A) Birth centers. Birth centers are eligible to participate in the Medicaid program if they are licensed or receive reimbursement from at least two third-party payors.

This rule is intended to implement Iowa Code section 249A.4.

441—77.28(249A) Area education agencies. An area education agency is eligible to participate in the Medicaid program when it has a plan for providing comprehensive special education programs and services approved by the Iowa department of education. Covered services shall be provided by personnel who are licensed, endorsed, or registered as provided in this rule and shall be within the scope of the applicable license, endorsement, or registration.

77.28(1) Personnel providing audiological or speech-language services shall be licensed by the Iowa board of speech pathology and audiology as a speech pathologist or audiologist pursuant to 645—Chapters 299, 300 and 303 through 305.

77.28(2) Personnel providing physical therapy shall be licensed by the Iowa board of physical and occupational therapy as a physical therapist pursuant to 645—Chapters 199 through 204.

77.28(3) Personnel providing occupational therapy shall be licensed by the Iowa board of physical and occupational therapy as an occupational therapist pursuant to 645—Chapters 205 through 210.

77.28(4) Personnel providing psychological evaluations and counseling or psychotherapy services shall be:

- a.* Endorsed by the Iowa board of educational examiners as a school psychologist pursuant to rule 282—15.11(272);
- b.* Licensed by the Iowa board of psychology as a psychologist pursuant to 645—Chapters 239 through 243;
- c.* Licensed by the Iowa board of social work as a social worker pursuant to 645—Chapters 279 through 284;
- d.* Licensed by the Iowa board of medicine as a physician pursuant to 653—Chapters 9 through 11; or
- e.* Registered by the Iowa nursing board as an advanced registered nurse practitioner pursuant to 655—Chapter 7.

77.28(5) Personnel providing nursing services shall be licensed by the Iowa nursing board as a registered or licensed practical nurse pursuant to 655—Chapters 3 through 6.

77.28(6) Personnel providing vision services shall be:

- a.* Licensed by the Iowa nursing board as a registered or licensed practical nurse pursuant to 655—Chapters 3 through 6;
 - b.* Licensed by the Iowa board of medicine as a physician pursuant to 653—Chapters 9 through 11; or
 - c.* Licensed by the Iowa board of optometry as an optometrist pursuant to 645—Chapter 180.
- This rule is intended to implement Iowa Code section 249A.4.

441—77.29(249A) Case management provider organizations. Case management provider organizations are eligible to participate in the Medicaid program provided that they meet the standards for the populations being served. Providers shall meet the following standards:

77.29(1) Standards in 441—Chapter 24. Providers shall meet the standards in 441—Chapter 24 when they are the department of human services, a county or consortium of counties, or an agency or provider under subcontract to the department or a county or consortium of counties providing case management services to persons with mental retardation, developmental disabilities or chronic mental illness.

77.29(2) Standards in 441—Chapter 186. Rescinded IAB 10/12/05, effective 10/1/05.

441—77.30(249A) HCBS health and disability waiver service providers. HCBS health and disability waiver services shall be rendered by a person who is at least 16 years old (except as otherwise provided in this rule) and is not the spouse of the member served or the parent or stepparent of a member aged 17 or under. People who are 16 or 17 years old must be employed and supervised by an enrolled HCBS provider unless they are employed to provide self-directed personal care services through the consumer choices option. A person hired for self-directed personal care services need not be supervised by an enrolled HCBS provider. A provider hired through the consumer choices option for independent support brokerage, self-directed personal care, individual-directed goods and services, or self-directed community support and employment is not required to enroll as a Medicaid provider. The following providers shall be eligible to participate in the Medicaid HCBS health and disability waiver program if they meet the standards in subrule 77.30(18) and also meet the standards set forth below for the service to be provided:

77.30(1) Homemaker providers. Homemaker providers shall be agencies that are:

- a.* Certified as a home health agency under Medicare, or
- b.* Authorized to provide similar services through a contract with the department of public health (IDPH) for local public health services. The agency must provide a current IDPH local public health services contract number.

77.30(2) Home health aide providers. Home health aide providers shall be agencies which are certified to participate in the Medicare program.

77.30(3) Adult day care providers. Adult day care providers shall be agencies that are certified by the department of inspections and appeals as being in compliance with the standards for adult day services programs at 481—Chapter 70.

77.30(4) Nursing care providers. Nursing care providers shall be agencies which are certified to participate in the Medicare program as home health agencies.

77.30(5) Respite care providers.

a. The following agencies may provide respite services:

- (1) Home health agencies that are certified to participate in the Medicare program.
- (2) Respite providers certified under the home- and community-based services intellectual disability or brain injury waiver.
- (3) Nursing facilities, intermediate care facilities for the mentally retarded, and hospitals enrolled as providers in the Iowa Medicaid program.
- (4) Group living foster care facilities for children licensed by the department according to 441—Chapters 112 and 114 to 116 and child care centers licensed according to 441—Chapter 109.
- (5) Camps certified by the American Camping Association.
- (6) Home care agencies that meet the conditions of participation set forth in subrule 77.30(1).
- (7) Adult day care providers that meet the conditions of participation set forth in subrule 77.30(3).
- (8) Residential care facilities for persons with mental retardation licensed by the department of inspections and appeals.

(9) Assisted living programs certified by the department of inspections and appeals.

b. Respite providers shall meet the following conditions:

- (1) Providers shall maintain the following information that shall be updated at least annually:
 1. The consumer's name, birth date, age, and address and the telephone number of each parent, guardian or primary caregiver.
 2. An emergency medical care release.
 3. Emergency contact telephone numbers such as the number of the consumer's physician and the parents, guardian, or primary caregiver.
 4. The consumer's medical issues, including allergies.
 5. The consumer's daily schedule which includes the consumer's preferences in activities or foods or any other special concerns.

(2) Procedures shall be developed for the dispensing, storage, authorization, and recording of all prescription and nonprescription medications administered. Home health agencies must follow Medicare regulations for medication dispensing.

All medications shall be stored in their original containers, with the accompanying physician's or pharmacist's directions and label intact. Medications shall be stored so they are inaccessible to consumers and the public. Nonprescription medications shall be labeled with the consumer's name.

In the case of medications that are administered on an ongoing, long-term basis, authorization shall be obtained for a period not to exceed the duration of the prescription.

(3) Policies shall be developed for:

1. Notifying the parent, guardian or primary caregiver of any injuries or illnesses that occur during respite provision. A parent's, guardian's or primary caregiver's signature is required to verify receipt of notification.
2. Requiring the parent, guardian or primary caregiver to notify the respite provider of any injuries or illnesses that occurred prior to respite provision.
3. Documenting activities and times of respite. This documentation shall be made available to the parent, guardian or primary caregiver upon request.
4. Ensuring the safety and privacy of the individual. Policies shall at a minimum address threat of fire, tornado, or flood and bomb threats.

c. A facility providing respite under this subrule shall not exceed the facility's licensed capacity, and services shall be provided in locations consistent with licensure.

d. Respite provided outside the consumer's home or the facility covered by the licensure, certification, accreditation, or contract must be approved by the parent, guardian or primary caregiver and the interdisciplinary team and must be consistent with the way the location is used by the general public. Respite in these locations shall not exceed 72 continuous hours.

77.30(6) Counseling providers. Counseling providers shall be:

a. Agencies which are certified under the community mental health center standards established by the mental health and developmental disabilities commission, set forth in 441—Chapter 24, Divisions I and III.

b. Agencies which are licensed as meeting the hospice standards and requirements set forth in department of inspections and appeals rules 481—Chapter 53 or which are certified to meet the standards under the Medicare program for hospice programs.

c. Agencies which are accredited under the mental health service provider standards established by the mental health and developmental disabilities commission, set forth in 441—Chapter 24, Divisions I and IV.

77.30(7) Consumer-directed attendant care providers. The following providers may provide consumer-directed attendant care service:

- a. An individual who contracts with the member to provide attendant care service and who is:
- (1) At least 18 years of age.
 - (2) Qualified by training or experience to carry out the member's plan of care pursuant to the department-approved case plan or individual comprehensive plan.
 - (3) Not the spouse of the member or a parent or stepparent of a member aged 17 or under.
 - (4) Not the recipient of respite services paid through home- and community-based services on behalf of a member who receives home- and community-based services.

b. Agencies authorized to provide similar services through a contract with the department of public health (IDPH) for local public health services. The agency must provide a current IDPH local public health services contract number.

c. Home health agencies which are certified to participate in the Medicare program.

d. Chore providers subcontracting with area agencies on aging or with letters of approval from the area agencies on aging stating that the organization is qualified to provide chore services.

e. Community action agencies as designated in Iowa Code section 216A.93.

f. Providers certified under an HCBS waiver for supported community living.

g. Assisted living programs that are certified by the department of inspections and appeals under 481—Chapter 69.

h. Adult day service providers that are certified by the department of inspections and appeals under 481—Chapter 70.

77.30(8) Interim medical monitoring and treatment providers.

a. The following providers may provide interim medical monitoring and treatment services:

- (1) Home health agencies certified to participate in the Medicare program.
- (2) Supported community living providers certified according to subrule 77.37(14) or 77.39(13).

b. Staff requirements. Staff members providing interim medical monitoring and treatment services to members shall meet all of the following requirements:

- (1) Be at least 18 years of age.
- (2) Not be the spouse of the member or a parent or stepparent of the member if the member is aged 17 or under.

- (3) Not be a usual caregiver of the member.

- (4) Be qualified by training or experience to provide medical intervention or intervention in a medical emergency necessary to carry out the member's plan of care. The training or experience required must be determined by the member's usual caregivers and a licensed medical professional on the member's interdisciplinary team and must be documented in the member's service plan.

c. Service documentation. Providers shall maintain clinical and fiscal records necessary to fully disclose the extent of services furnished to members. Records shall specify by service date the procedures performed, together with information concerning progress of treatment.

77.30(9) Home and vehicle modification providers. The following providers may provide home and vehicle modification:

a. Area agencies on aging as designated in 17—4.4(231).

b. Community action agencies as designated in Iowa Code section 216A.93.

c. Providers eligible to participate as home and vehicle modification providers under the elderly waiver, enrolled as home and vehicle modification providers under the physical disability waiver, or certified as home and vehicle modification providers under the home- and community-based services intellectual disability or brain injury waiver.

d. Community businesses that have all necessary licenses and permits to operate in conformity with federal, state, and local laws and regulations, and that submit verification of current liability and workers' compensation coverage.

77.30(10) *Personal emergency response system providers.* Personal emergency response system providers shall be agencies that meet the conditions of participation set forth in subrule 77.33(2).

77.30(11) *Home-delivered meals.* The following providers may provide home-delivered meals:

a. Area agencies on aging as designated in 17—4.4(231). Home-delivered meals providers subcontracting with area agencies on aging or with letters of approval from the area agencies on aging stating the organization is qualified to provide home-delivered meals services may also provide home-delivered meals services.

b. Community action agencies as designated in Iowa Code section 216A.93.

c. Nursing facilities licensed pursuant to Iowa Code chapter 135C.

d. Restaurants licensed and inspected under Iowa Code chapter 137F.

e. Hospitals enrolled as Medicaid providers.

f. Home health aide providers meeting the standards set forth in subrule 77.33(3).

g. Medical equipment and supply dealers certified to participate in the Medicaid program.

h. Home care providers meeting the standards set forth in subrule 77.33(4).

77.30(12) *Nutritional counseling.* The following providers may provide nutritional counseling by a dietitian licensed under 645—Chapter 81:

a. Hospitals enrolled as Medicaid providers.

b. Community action agencies as designated in Iowa Code section 216A.93.

c. Nursing facilities licensed pursuant to Iowa Code chapter 135C.

d. Home health agencies certified by Medicare.

e. Independent licensed dietitians approved by an area agency on aging.

77.30(13) *Financial management service.* Members who elect the consumer choices option shall work with a financial institution that meets the following qualifications.

a. The financial institution shall either:

(1) Be cooperative, nonprofit, member-owned and member-controlled, and federally insured through and chartered by either the National Credit Union Administration (NCUA) or the credit union division of the Iowa department of commerce; or

(2) Be chartered by the Office of the Comptroller of the Currency, a bureau of the U.S. Department of the Treasury, and insured by the Federal Deposit Insurance Corporation (FDIC).

b. The financial institution shall complete a financial management readiness review and certification conducted by the department or its designee.

c. The financial institution shall obtain an Internal Revenue Service federal employee identification number dedicated to the financial management service.

d. The financial institution shall enroll as a Medicaid provider.

77.30(14) *Independent support brokerage.* Members who elect the consumer choices option shall work with an independent support broker who meets the following qualifications.

a. The broker must be at least 18 years of age.

b. The broker shall not be the member's guardian, conservator, attorney in fact under a durable power of attorney for health care, power of attorney for financial matters, trustee, or representative payee.

c. The broker shall not provide any other paid service to the member.

d. The broker shall not work for an individual or entity that is providing services to the member.

e. The broker must consent to a criminal background check and child and dependent adult abuse checks. The results shall be provided to the member.

f. The broker must complete independent support brokerage training approved by the department.

77.30(15) *Self-directed personal care.* Members who elect the consumer choices option may choose to purchase self-directed personal care services from an individual or business that meets the following requirements.

- a.* A business providing self-directed personal care services shall:
 - (1) Have all the necessary licenses and permits to operate in conformity with federal, state, and local laws and regulations; and
 - (2) Have current liability and workers' compensation coverage.
- b.* An individual providing self-directed personal care services shall have all the necessary licenses required by federal, state, and local laws, including a valid driver's license if providing transportation.
- c.* All personnel providing self-directed personal care services shall:
 - (1) Be at least 16 years of age.
 - (2) Be able to communicate successfully with the member.
 - (3) Not be the recipient of respite services paid through home- and community-based services on behalf of a member who receives home- and community-based services.
 - (4) Not be the recipient of respite services paid through the consumer choices option on behalf of a member who receives the consumer choices option.
 - (5) Not be the parent or stepparent of a minor child member or the spouse of a member.
- d.* The provider of self-directed personal care services shall:
 - (1) Prepare timecards or invoices approved by the department that identify what services were provided and the time when services were provided.
 - (2) Submit invoices and timesheets to the financial management service no later than 30 calendar days from the date when the last service in the billing period was provided. Payment shall not be made if invoices and timesheets are received after this 30-day period.

77.30(16) *Individual-directed goods and services.* Members who elect the consumer choices option may choose to purchase individual-directed goods and services from an individual or business that meets the following requirements.

- a.* A business providing individual-directed goods and services shall:
 - (1) Have all the necessary licenses and permits to operate in conformity with federal, state, and local laws and regulations; and
 - (2) Have current liability and workers' compensation coverage.
- b.* An individual providing individual-directed goods and services shall have all the necessary licenses required by federal, state, and local laws, including a valid driver's license if providing transportation.
- c.* All personnel providing individual-directed goods and services shall:
 - (1) Be at least 18 years of age.
 - (2) Be able to communicate successfully with the member.
 - (3) Not be the recipient of respite services paid through home- and community-based services on behalf of a member who receives home- and community-based services.
 - (4) Not be the recipient of respite services paid through the consumer choices option on behalf of a member who receives the consumer choices option.
 - (5) Not be the parent or stepparent of a minor child member or the spouse of a member.
- d.* The provider of individual-directed goods and services shall:
 - (1) Prepare timecards or invoices approved by the department that identify what services were provided and the time when services were provided.
 - (2) Submit invoices and timesheets to the financial management service no later than 30 calendar days from the date when the last service in the billing period was provided. Payment shall not be made if invoices and timesheets are received after this 30-day period.

77.30(17) *Self-directed community supports and employment.* Members who elect the consumer choices option may choose to purchase self-directed community supports and employment from an individual or business that meets the following requirements.

- a.* A business providing community supports and employment shall:

(1) Have all the necessary licenses and permits to operate in conformity with federal, state, and local laws and regulations; and

(2) Have current liability and workers' compensation coverage.

b. An individual providing self-directed community supports and employment shall have all the necessary licenses required by federal, state, and local laws, including a valid driver's license if providing transportation.

c. All personnel providing self-directed community supports and employment shall:

(1) Be at least 18 years of age.

(2) Be able to communicate successfully with the member.

(3) Not be the recipient of respite services paid through home- and community-based services on behalf of a member who receives home- and community-based services.

(4) Not be the recipient of respite services paid through the consumer choices option on behalf of a member who receives the consumer choices option.

(5) Not be the parent or stepparent of a minor child member or the spouse of a member.

d. The provider of self-directed community supports and employment shall:

(1) Prepare timecards or invoices approved by the department that identify what services were provided and the time when services were provided.

(2) Submit invoices and timesheets to the financial management service no later than 30 calendar days from the date when the last service in the billing period was provided. Payment shall not be made if invoices and timesheets are received after this 30-day period.

77.30(18) Incident management and reporting. As a condition of participation in the medical assistance program, HCBS health and disability waiver service providers must comply with the requirements of Iowa Code sections 232.69 and 235B.3 regarding the reporting of child abuse and dependent adult abuse and with the incident management and reporting requirements in this subrule. EXCEPTION: The conditions in this subrule do not apply to providers of goods and services purchased under the consumer choices option or providers of home and vehicle modification, home-delivered meals, or personal emergency response.

a. *Definitions.*

"Major incident" means an occurrence involving a consumer during service provision that:

1. Results in a physical injury to or by the consumer that requires a physician's treatment or admission to a hospital;

2. Results in the death of any person;

3. Requires emergency mental health treatment for the consumer;

4. Requires the intervention of law enforcement;

5. Requires a report of child abuse pursuant to Iowa Code section 232.69 or a report of dependent adult abuse pursuant to Iowa Code section 235B.3;

6. Constitutes a prescription medication error or a pattern of medication errors that leads to the outcome in paragraph "1," "2," or "3"; or

7. Involves a consumer's location being unknown by provider staff who are assigned protective oversight.

"Minor incident" means an occurrence involving a consumer during service provision that is not a major incident and that:

1. Results in the application of basic first aid;

2. Results in bruising;

3. Results in seizure activity;

4. Results in injury to self, to others, or to property; or

5. Constitutes a prescription medication error.

b. *Reporting procedure for minor incidents.* Minor incidents may be reported in any format designated by the provider. When a minor incident occurs or a staff member becomes aware of a minor incident, the staff member involved shall submit the completed incident report to the staff member's supervisor within 72 hours of the incident. The completed report shall be maintained in a centralized file with a notation in the consumer's file.

c. Reporting procedure for major incidents. When a major incident occurs or a staff member becomes aware of a major incident:

(1) The staff member involved shall notify the following persons of the incident by the end of the next calendar day after the incident:

1. The staff member's supervisor.

2. The consumer or the consumer's legal guardian. EXCEPTION: Notification to the consumer is required only if the incident took place outside of the provider's service provision. Notification to the guardian, if any, is always required.

3. The consumer's case manager.

(2) By the end of the next calendar day after the incident, the staff member who observed or first became aware of the incident shall also report as much information as is known about the incident to the department's bureau of long-term care either:

1. By direct data entry into the Iowa Medicaid Provider Access System, or

2. By faxing or mailing Form 470-4698, Critical Incident Report, according to the directions on the form.

(3) The following information shall be reported:

1. The name of the consumer involved.

2. The date and time the incident occurred.

3. A description of the incident.

4. The names of all provider staff and others who were present at the time of the incident or who responded after becoming aware of the incident. The confidentiality of other waiver-eligible or non-waiver-eligible consumers who were present must be maintained by the use of initials or other means.

5. The action that the provider staff took to manage the incident.

6. The resolution of or follow-up to the incident.

7. The date the report is made and the handwritten or electronic signature of the person making the report.

(4) Submission of the initial report will generate a workflow in the Individualized Services Information System (ISIS) for follow-up by the case manager. When complete information about the incident is not available at the time of the initial report, the provider must submit follow-up reports until the case manager is satisfied with the incident resolution and follow-up. The completed report shall be maintained in a centralized file with a notation in the consumer's file.

d. Tracking and analysis. The provider shall track incident data and analyze trends to assess the health and safety of consumers served and determine if changes need to be made for service implementation or if staff training is needed to reduce the number or severity of incidents.

This rule is intended to implement Iowa Code section 249A.4.

[ARC 7936B, IAB 7/1/09, effective 9/1/09; ARC 9314B, IAB 12/29/10, effective 3/1/11; ARC 0757C, IAB 5/29/13, effective 8/1/13; ARC 1149C, IAB 10/30/13, effective 1/1/14]

441—77.31(249A) Occupational therapists. Occupational therapists are eligible to participate if they are licensed and in private practice independent of the administrative and professional control of an employer such as a physician, institution, or rehabilitation agency. Licensed occupational therapists in an independent group practice are eligible to enroll.

77.31(1) Occupational therapists in other states are eligible to participate if they are licensed in that state and meet the Medicare criteria for enrollment.

77.31(2) Occupational therapists who provide services to Medicaid members who are also Medicare beneficiaries must be enrolled in the Medicare program.

This rule is intended to implement Iowa Code section 249A.4.

441—77.32(249A) Hospice providers. Hospice providers are eligible to participate in the Medicaid program providing they are certified to participate in the Medicare program.

This rule is intended to implement Iowa Code section 249A.4.

441—77.33(249A) HCBS elderly waiver service providers. HCBS elderly waiver services shall be rendered by a person who is at least 16 years old (except as otherwise provided in this rule) and is not the spouse of the consumer served or the parent or stepparent of a consumer aged 17 or under. People who are 16 or 17 years old must be employed and supervised by an enrolled HCBS provider unless they are employed to provide self-directed personal care services through the consumer choices option. A person hired for self-directed personal care services need not be supervised by an enrolled HCBS provider. A person hired through the consumer choices option for independent support brokerage, self-directed personal care, individual-directed goods and services, or self-directed community support and employment is not required to enroll as a Medicaid provider. The following providers shall be eligible to participate in the Medicaid HCBS elderly waiver program if they meet the standards in subrule 77.33(22) and also meet the standards set forth below for the service to be provided:

77.33(1) Adult day care providers. Adult day care providers shall be agencies that are certified by the department of inspections and appeals as being in compliance with the standards for adult day services programs at 481—Chapter 70.

77.33(2) Emergency response system providers. Emergency response system providers must meet the following standards:

a. The agency shall provide an electronic component to transmit a coded signal via digital equipment over telephone lines to a central monitoring station. The central monitoring station must operate receiving equipment and be fully staffed by trained attendants, 24 hours a day, seven days per week. The attendants must process emergency calls and ensure the timely notification of appropriate emergency resources to be dispatched to the person in need.

b. The agency, parent agency, institution or corporation shall have the necessary legal authority to operate in conformity with federal, state and local laws and regulations.

c. There shall be a governing authority which is responsible for establishing policy and ensuring effective control of services and finances. The governing authority shall employ or contract for an agency administrator to whom authority and responsibility for overall agency administration are delegated.

d. The agency or institution shall be in compliance with all legislation relating to prohibition of discriminatory practices.

e. There shall be written policies and procedures established to explain how the service operates, agency responsibilities, client responsibilities and cost information.

77.33(3) Home health aide providers. Home health aide providers shall be agencies certified to participate in the Medicare program as home health agencies.

77.33(4) Homemaker providers. Homemaker providers shall be agencies that are:

a. Certified as a home health agency under Medicare, or

b. Authorized to provide similar services through a contract with the department of public health (IDPH) for local public health services. The agency must provide a current IDPH local public health services contract number.

77.33(5) Nursing care. Nursing care providers shall be agencies which are certified to participate in the Medicare program as home health agencies.

77.33(6) Respite care providers.

a. The following agencies may provide respite services:

(1) Home health agencies that are certified to participate in the Medicare program.

(2) Nursing facilities and hospitals enrolled as providers in the Iowa Medicaid program.

(3) Camps certified by the American Camping Association.

(4) Respite providers certified under the home- and community-based services intellectual disability waiver.

(5) Home care agencies that meet the conditions of participation set forth in subrule 77.33(4).

(6) Adult day care providers that meet the conditions set forth in subrule 77.33(1).

(7) Assisted living programs certified by the department of inspections and appeals.

b. Respite providers shall meet the following conditions:

(1) Providers shall maintain the following information that shall be updated at least annually:

1. The consumer's name, birth date, age, and address and the telephone number of the spouse, guardian or primary caregiver.
2. An emergency medical care release.
3. Emergency contact telephone numbers such as the number of the consumer's physician and the spouse, guardian, or primary caregiver.
4. The consumer's medical issues, including allergies.
5. The consumer's daily schedule which includes the consumer's preferences in activities or foods or any other special concerns.

(2) Procedures shall be developed for the dispensing, storage, authorization, and recording of all prescription and nonprescription medications administered. Home health agencies must follow Medicare regulations for medication dispensing.

All medications shall be stored in their original containers, with the accompanying physician's or pharmacist's directions and label intact. Medications shall be stored so they are inaccessible to consumers and the public. Nonprescription medications shall be labeled with the consumer's name.

In the case of medications that are administered on an ongoing, long-term basis, authorization shall be obtained for a period not to exceed the duration of the prescription.

(3) Policies shall be developed for:

1. Notifying the spouse, guardian, or primary caregiver of any injuries or illnesses that occur during respite provision. A spouse's, guardian's or primary caregiver's signature is required to verify receipt of notification.

2. Requiring the spouse, guardian or primary caregiver to notify the respite provider of any injuries or illnesses that occurred prior to respite provision.

3. Documenting activities and times of respite. This documentation shall be made available to the spouse, guardian or primary caregiver upon request.

4. Ensuring the safety and privacy of the individual. Policies shall at a minimum address threat of fire, tornado, or flood and bomb threats.

c. A facility providing respite under this subrule shall not exceed the facility's licensed capacity, and services shall be provided in locations consistent with licensure.

d. Respite provided outside the consumer's home or the facility covered by the licensure, certification, accreditation, or contract must be approved by the spouse, guardian or primary caregiver and the interdisciplinary team and must be consistent with the way the location is used by the general public. Respite in these locations shall not exceed 72 continuous hours.

77.33(7) *Chore providers.* The following providers may provide chore services:

- a. Home health agencies certified under Medicare.

- b. Community action agencies as designated in Iowa Code section 216A.93.

- c. Agencies authorized to provide similar services through a contract with the department of public health (IDPH) for local public health services. The agency must provide a current IDPH local public health services contract number.

- d. Nursing facilities licensed pursuant to Iowa Code chapter 135C.

- e. Providers that were enrolled as chore providers as of June 30, 2010, based on a subcontract with or letter of approval from an area agency on aging.

- f. Community businesses that are engaged in the provision of chore services and that:

- (1) Have all necessary licenses and permits to operate in conformity with federal, state, and local laws and regulations, and

- (2) Submit verification of current liability and workers' compensation coverage.

77.33(8) *Home-delivered meals.* The following providers may provide home-delivered meals:

- a. Area agencies on aging as designated in 17—4.4(231). Home-delivered meals providers subcontracting with area agencies on aging or with letters of approval from the area agencies on aging stating the organization is qualified to provide home-delivered meals services may also provide home-delivered meals services.

- b. Community action agencies as designated in Iowa Code section 216A.93.

- c. Nursing facilities licensed pursuant to Iowa Code chapter 135C.

- d. Restaurants licensed and inspected under Iowa Code chapter 137F.
- e. Hospitals enrolled as Medicaid providers.
- f. Home health aide providers meeting the standards set forth in subrule 77.33(3).
- g. Medical equipment and supply dealers certified to participate in the Medicaid program.
- h. Home care providers meeting the standards set forth in subrule 77.33(4).

77.33(9) *Home and vehicle modification providers.* The following providers may provide home and vehicle modification:

- a. Area agencies on aging as designated in 17—4.4(231).
- b. Community action agencies as designated in Iowa Code section 216A.93.
- c. Providers eligible to participate as home and vehicle modification providers under the health and disability waiver, enrolled as home and vehicle modification providers under the physical disability waiver, or certified as home and vehicle modification providers under the home- and community-based services intellectual disability or brain injury waiver.
- d. Community businesses that have all necessary licenses and permits to operate in conformity with federal, state, and local laws and regulations, and that submit verification of current liability and workers' compensation coverage.

77.33(10) *Mental health outreach providers.* Community mental health centers or other mental health providers accredited by the mental health and developmental disabilities commission pursuant to 441—Chapter 24 may provide mental health outreach services.

77.33(11) *Transportation providers.* The following providers may provide transportation:

- a. Area agencies on aging as designated in 17—4.4(231). Transportation providers subcontracting with area agencies on aging or with letters of approval from the area agencies on aging stating the organization is qualified to provide transportation services may also provide transportation services.
- b. Community action agencies as designated in Iowa Code section 216A.93.
- c. Regional transit agencies as recognized by the Iowa department of transportation.
- d. Rescinded IAB 3/10/99, effective 5/1/99.
- e. Nursing facilities licensed pursuant to Iowa Code chapter 135C.
- f. Transportation providers contracting with the nonemergency medical transportation contractor.

77.33(12) *Nutritional counseling.* The following providers may provide nutritional counseling by a dietitian licensed under 645—Chapter 81:

- a. Hospitals enrolled as Medicaid providers.
- b. Community action agencies as designated in Iowa Code section 216A.93.
- c. Nursing facilities licensed pursuant to Iowa Code chapter 135C.
- d. Home health agencies certified by Medicare.
- e. Independent licensed dietitians.

77.33(13) *Assistive device providers.* The following providers may provide assistive devices:

- a. Medicaid-enrolled medical equipment and supply dealers.
- b. Area agencies on aging as designated according to department on aging rules 17—4.4(231) and 17—4.9(231).
- c. Providers that were enrolled as assistive device providers as of June 30, 2010, based on a contract with or letter of approval from an area agency on aging.
- d. Community businesses that are engaged in the provision of assistive devices and that:
 - (1) Have all necessary licenses and permits to operate in conformity with federal, state, and local laws and regulations, and
 - (2) Submit verification of current liability and workers' compensation coverage.

77.33(14) *Senior companions.* Senior companion programs designated by the Corporation for National and Community Service may provide senior companion service.

77.33(15) *Consumer-directed attendant care providers.* The following providers may provide consumer-directed attendant care service:

- a. An individual who contracts with the member to provide attendant care service and who is:
 - (1) At least 18 years of age.

(2) Qualified by training or experience to carry out the member's plan of care pursuant to the department-approved case plan or individual comprehensive plan.

(3) Not the spouse of the member or a parent or stepparent of a member aged 17 or under.

(4) Not the recipient of respite services paid through home- and community-based services on behalf of a member who receives home- and community-based services.

b. Agencies authorized to provide similar services through a contract with the department of public health (IDPH) for local public health services. The agency must provide a current IDPH local public health services contract number.

c. Home health agencies which are certified to participate in the Medicare program.

d. Chore providers subcontracting with area agencies on aging or with letters of approval from the area agencies on aging stating that the organization is qualified to provide chore services.

e. Community action agencies as designated in Iowa Code section 216A.93.

f. Providers certified under an HCBS waiver for supported community living.

g. Assisted living programs that are certified by the department of inspections and appeals under 481—Chapter 69.

h. Adult day service providers that are certified by the department of inspections and appeals under 481—Chapter 70.

77.33(16) *Financial management service.* Consumers who elect the consumer choices option shall work with a financial institution that meets the qualifications in subrule 77.30(13).

77.33(17) *Independent support brokerage.* Consumers who elect the consumer choices option shall work with an independent support broker who meets the qualifications in subrule 77.30(14).

77.33(18) *Self-directed personal care.* Consumers who elect the consumer choices option may choose to purchase self-directed personal care services from an individual or business that meets the requirements in subrule 77.30(15).

77.33(19) *Individual-directed goods and services.* Consumers who elect the consumer choices option may choose to purchase individual-directed goods and services from an individual or business that meets the requirements in subrule 77.30(16).

77.33(20) *Self-directed community supports and employment.* Consumers who elect the consumer choices option may choose to purchase self-directed community supports and employment from an individual or business that meets the requirements in subrule 77.30(17).

77.33(21) *Case management providers.* A case management provider organization is eligible to participate in the Medicaid HCBS elderly waiver program if the organization meets the following standards:

a. The case management provider shall be an agency or individual that:

(1) Is accredited by the mental health, mental retardation, developmental disabilities, and brain injury commission as meeting the standards for case management services in 441—Chapter 24; or

(2) Is accredited through the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) to provide case management; or

(3) Is accredited through the Council on Accreditation of Rehabilitation Facilities (CARF) to provide case management; or

(4) Is accredited through the Council on Quality and Leadership in Supports for People with Disabilities (CQL) to provide case management; or

(5) Is approved by the department on aging as meeting the standards for case management services in 17—Chapter 21; or

(6) Is authorized to provide similar services through a contract with the department of public health (IDPH) for local public health services and that:

1. Meets the qualifications for case managers in 641—subrule 80.6(1); and

2. Provides a current IDPH local public health services contract number.

b. A case management provider shall not provide direct services to the consumer. The department and the Centers for Medicare and Medicaid Services deem the provision of direct services to case management consumers to be a conflict of interest. A person cannot be the first-line supervisor of both

case managers and direct service staff who are providing services to elderly waiver consumers. The provider must have written conflict of interest policies that include, but are not limited to:

- (1) Specific procedures to identify conflicts of interest.
- (2) Procedures to eliminate any conflict of interest that is identified.
- (3) Procedures for handling complaints of conflict of interest, including written documentation.

c. If the case management provider organization subcontracts case management services to another entity:

- (1) That entity must also meet the provider qualifications in this subrule; and
- (2) The contractor is responsible for verification of compliance.

77.33(22) Incident management and reporting. As a condition of participation in the medical assistance program, HCBS elderly waiver service providers must comply with the requirements of Iowa Code sections 232.69 and 235B.3 regarding the reporting of child abuse and dependent adult abuse and with the incident management and reporting requirements in this subrule. EXCEPTION: The conditions in this subrule do not apply to providers of assistive devices, chore service, goods and services purchased under the consumer choices option, home and vehicle modification, home-delivered meals, personal emergency response, or transportation.

a. *Definitions.*

“Major incident” means an occurrence involving a consumer during service provision that:

1. Results in a physical injury to or by the consumer that requires a physician’s treatment or admission to a hospital;
2. Results in the death of any person;
3. Requires emergency mental health treatment for the consumer;
4. Requires the intervention of law enforcement;
5. Requires a report of child abuse pursuant to Iowa Code section 232.69 or a report of dependent adult abuse pursuant to Iowa Code section 235B.3;
6. Constitutes a prescription medication error or a pattern of medication errors that leads to the outcome in paragraph “1,” “2,” or “3”; or
7. Involves a consumer’s location being unknown by provider staff who are assigned protective oversight.

“Minor incident” means an occurrence involving a consumer during service provision that is not a major incident and that:

1. Results in the application of basic first aid;
2. Results in bruising;
3. Results in seizure activity;
4. Results in injury to self, to others, or to property; or
5. Constitutes a prescription medication error.

b. *Reporting procedure for minor incidents.* Minor incidents may be reported in any format designated by the provider. When a minor incident occurs or a staff member becomes aware of a minor incident, the staff member involved shall submit the completed incident report to the staff member’s supervisor within 72 hours of the incident. The completed report shall be maintained in a centralized file with a notation in the consumer’s file.

c. *Reporting procedure for major incidents.* When a major incident occurs or a staff member becomes aware of a major incident:

(1) The staff member involved shall notify the following persons of the incident by the end of the next calendar day after the incident:

1. The staff member’s supervisor.
2. The consumer or the consumer’s legal guardian. EXCEPTION: Notification to the consumer is required only if the incident took place outside of the provider’s service provision. Notification to the guardian, if any, is always required.
3. The consumer’s case manager.

(2) By the end of the next calendar day after the incident, the staff member who observed or first became aware of the incident shall also report as much information as is known about the incident to the department's bureau of long-term care either:

1. By direct data entry into the Iowa Medicaid Provider Access System, or
2. By faxing or mailing Form 470-4698, Critical Incident Report, according to the directions on the form.

(3) The following information shall be reported:

1. The name of the consumer involved.
2. The date and time the incident occurred.
3. A description of the incident.
4. The names of all provider staff and others who were present at the time of the incident or who responded after becoming aware of the incident. The confidentiality of other waiver-eligible or non-waiver-eligible consumers who were present must be maintained by the use of initials or other means.
5. The action that the provider staff took to manage the incident.
6. The resolution of or follow-up to the incident.
7. The date the report is made and the handwritten or electronic signature of the person making the report.

(4) Submission of the initial report will generate a workflow in the Individualized Services Information System (ISIS) for follow-up by the case manager. When complete information about the incident is not available at the time of the initial report, the provider must submit follow-up reports until the case manager is satisfied with the incident resolution and follow-up. The completed report shall be maintained in a centralized file with a notation in the consumer's file.

d. Tracking and analysis. The provider shall track incident data and analyze trends to assess the health and safety of consumers served and determine if changes need to be made for service implementation or if staff training is needed to reduce the number or severity of incidents.

77.33(23) Assisted living on-call service. Assisted living on-call service providers shall be assisted living programs that are certified by the department of inspections and appeals under 481—Chapter 69.

This rule is intended to implement Iowa Code section 249A.4.

[ARC 7936B, IAB 7/1/09, effective 9/1/09; ARC 9314B, IAB 12/29/10, effective 3/1/11; ARC 0545C, IAB 1/9/13, effective 3/1/13; ARC 0757C, IAB 5/29/13, effective 8/1/13; ARC 1071C, IAB 10/2/13, effective 10/1/13]

441—77.34(249A) HCBS AIDS/HIV waiver service providers. HCBS AIDS/HIV waiver services shall be rendered by a person who is at least 16 years old (except as otherwise provided in this rule) and is not the spouse of the consumer served or the parent or stepparent of a consumer aged 17 or under. People who are 16 or 17 years old must be employed and supervised by an enrolled HCBS provider unless they are employed to provide self-directed personal care services through the consumer choices option. A person hired for self-directed personal care services need not be supervised by an enrolled HCBS provider. A person hired through the consumer choices option for independent support brokerage, self-directed personal care, individual-directed goods and services, or self-directed community support and employment is not required to enroll as a Medicaid provider. The following providers shall be eligible to participate in the Medicaid HCBS AIDS/HIV waiver program if they meet the standards in subrule 77.34(14) and also meet the standards set forth below for the service to be provided:

77.34(1) Counseling providers. Counseling providers shall be:

a. Agencies which are certified under the community mental health center standards established by the mental health and developmental disabilities commission, set forth in 441—Chapter 24, Divisions I and III.

b. Agencies which are licensed as meeting the hospice standards and requirements set forth in department of inspections and appeals rules 481—Chapter 53 or which are certified to meet the standards under the Medicare program for hospice programs.

c. Agencies which are accredited under the mental health service provider standards established by the mental health and developmental disabilities commission, set forth in 441—Chapter 24, Divisions I and IV.

77.34(2) Home health aide providers. Home health aide providers shall be agencies which are certified to participate in the Medicare program.

77.34(3) Homemaker providers. Homemaker providers shall be agencies that are:

- a. Certified as a home health agency under Medicare, or
- b. Authorized to provide similar services through a contract with the department of public health (IDPH) for local public health services. The agency must provide a current IDPH local public health services contract number.

77.34(4) Nursing care providers. Nursing care providers shall be agencies which are certified to meet the standards under the Medicare program for home health agencies.

77.34(5) Respite care providers.

- a. The following agencies may provide respite services:
 - (1) Home health agencies that are certified to participate in the Medicare program.
 - (2) Nursing facilities, intermediate care facilities for the mentally retarded, or hospitals enrolled as providers in the Iowa Medicaid program.
 - (3) Respite providers certified under the home- and community-based services intellectual disability or brain injury waiver.
 - (4) Group living foster care facilities for children licensed by the department according to 441—Chapters 112 and 114 to 116 and child care centers licensed according to 441—Chapter 109.
 - (5) Camps certified by the American Camping Association.
 - (6) Home care agencies that meet the conditions of participation set forth in subrule 77.34(3).
 - (7) Adult day care providers that meet the conditions of participation set forth in subrule 77.34(7).
 - (8) Assisted living programs certified by the department of inspections and appeals.
- b. Respite providers shall meet the following conditions:
 - (1) Providers shall maintain the following information that shall be updated at least annually:
 1. The consumer's name, birth date, age, and address and the telephone number of each parent, guardian or primary caregiver.
 2. An emergency medical care release.
 3. Emergency contact telephone numbers such as the number of the consumer's physician and the parents, guardian, or primary caregiver.
 4. The consumer's medical issues, including allergies.
 5. The consumer's daily schedule which includes the consumer's preferences in activities or foods or any other special concerns.
 - (2) Procedures shall be developed for the dispensing, storage, authorization, and recording of all prescription and nonprescription medications administered. Home health agencies must follow Medicare regulations for medication dispensing.

All medications shall be stored in their original containers, with the accompanying physician's or pharmacist's directions and label intact. Medications shall be stored so they are inaccessible to consumers and the public. Nonprescription medications shall be labeled with the consumer's name.

In the case of medications that are administered on an ongoing, long-term basis, authorization shall be obtained for a period not to exceed the duration of the prescription.

(3) Policies shall be developed for:

1. Notifying the parent, guardian or primary caregiver of any injuries or illnesses that occur during respite provision. A parent's, guardian's or primary caregiver's signature is required to verify receipt of notification.
2. Requiring the parent, guardian, or primary caregiver to notify the respite provider of any injuries or illnesses that occurred prior to respite provision.
3. Documenting activities and times of respite. This documentation shall be made available to the parent, guardian or primary caregiver upon request.

4. Ensuring the safety and privacy of the individual. Policies shall at a minimum address threat of fire, tornado, or flood and bomb threats.

c. A facility providing respite under this subrule shall not exceed the facility's licensed capacity, and services shall be provided in locations consistent with licensure.

d. Respite provided outside the consumer's home or the facility covered by the licensure, certification, accreditation, or contract must be approved by the parent, guardian or primary caregiver and the interdisciplinary team and must be consistent with the way the location is used by the general public. Respite in these locations shall not exceed 72 continuous hours.

77.34(6) *Home-delivered meals.* The following providers may provide home-delivered meals:

a. Home health aide providers meeting the standards set forth in subrule 77.34(2).

b. Home care providers meeting the standards set forth in subrule 77.34(3).

c. Hospitals enrolled as Medicaid providers.

d. Nursing facilities licensed pursuant to Iowa Code chapter 135C.

e. Restaurants licensed and inspected under Iowa Code chapter 137F.

f. Community action agencies as designated in Iowa Code section 216A.93. Home-delivered meals providers subcontracting with community action agencies or with letters of approval from the community action agencies stating the organization is qualified to provide home-delivered meals services may also provide home-delivered meals services.

g. Area agencies on aging as designated in 17—4.4(231). Home-delivered meals providers subcontracting with area agencies on aging or with letters of approval from the area agencies on aging stating the organization is qualified to provide home-delivered meals services may also provide home-delivered meals services.

h. Medical equipment and supply dealers certified to participate in the Medicaid program.

77.34(7) *Adult day care providers.* Adult day care providers shall be agencies that are certified by the department of inspections and appeals as being in compliance with the standards for adult day services programs at 481—Chapter 70.

77.34(8) *Consumer-directed attendant care providers.* The following providers may provide consumer-directed attendant care service:

a. An individual who contracts with the member to provide attendant care service and who is:

(1) At least 18 years of age.

(2) Qualified by training or experience to carry out the member's plan of care pursuant to the department-approved case plan or individual comprehensive plan.

(3) Not the spouse of the member or a parent or stepparent of a member aged 17 or under.

(4) Not the recipient of respite services paid through home- and community-based services on behalf of a member who receives home- and community-based services.

b. Agencies authorized to provide similar services through a contract with the department of public health (IDPH) for local public health services. The agency must provide a current IDPH local public health services contract number.

c. Home health agencies which are certified to participate in the Medicare program.

d. Chore providers subcontracting with area agencies on aging or with letters of approval from the area agencies on aging stating that the organization is qualified to provide chore services.

e. Community action agencies as designated in Iowa Code section 216A.93.

f. Providers certified under an HCBS waiver for supported community living.

g. Assisted living programs that are certified by the department of inspections and appeals under 481—Chapter 69.

h. Adult day service providers that are certified by the department of inspections and appeals under 481—Chapter 70.

77.34(9) *Financial management service.* Consumers who elect the consumer choices option shall work with a financial institution that meets the qualifications in subrule 77.30(13).

77.34(10) *Independent support brokerage.* Consumers who elect the consumer choices option shall work with an independent support broker who meets the qualifications in subrule 77.30(14).

77.34(11) *Self-directed personal care.* Consumers who elect the consumer choices option may choose to purchase self-directed personal care services from an individual or business that meets the requirements in subrule 77.30(15).

77.34(12) *Individual-directed goods and services.* Consumers who elect the consumer choices option may choose to purchase individual-directed goods and services from an individual or business that meets the requirements in subrule 77.30(16).

77.34(13) *Self-directed community supports and employment.* Consumers who elect the consumer choices option may choose to purchase self-directed community supports and employment from an individual or business that meets the requirements in subrule 77.30(17).

77.34(14) *Incident management and reporting.* As a condition of participation in the medical assistance program, HCBS AIDS/HIV waiver service providers must comply with the requirements of Iowa Code sections 232.69 and 235B.3 regarding the reporting of child abuse and dependent adult abuse and with the incident management and reporting requirements in this subrule. EXCEPTION: The conditions in this subrule do not apply to providers of goods and services purchased under the consumer choices option or to home-delivered meals.

a. Definitions.

“Major incident” means an occurrence involving a consumer during service provision that:

1. Results in a physical injury to or by the consumer that requires a physician’s treatment or admission to a hospital;
2. Results in the death of any person;
3. Requires emergency mental health treatment for the consumer;
4. Requires the intervention of law enforcement;
5. Requires a report of child abuse pursuant to Iowa Code section 232.69 or a report of dependent adult abuse pursuant to Iowa Code section 235B.3;
6. Constitutes a prescription medication error or a pattern of medication errors that leads to the outcome in paragraph “1,” “2,” or “3”; or
7. Involves a consumer’s location being unknown by provider staff who are assigned protective oversight.

“Minor incident” means an occurrence involving a consumer during service provision that is not a major incident and that:

1. Results in the application of basic first aid;
2. Results in bruising;
3. Results in seizure activity;
4. Results in injury to self, to others, or to property; or
5. Constitutes a prescription medication error.

b. Reporting procedure for minor incidents. Minor incidents may be reported in any format designated by the provider. When a minor incident occurs or a staff member becomes aware of a minor incident, the staff member involved shall submit the completed incident report to the staff member’s supervisor within 72 hours of the incident. The completed report shall be maintained in a centralized file with a notation in the consumer’s file.

c. Reporting procedure for major incidents. When a major incident occurs or a staff member becomes aware of a major incident:

(1) The staff member involved shall notify the following persons of the incident by the end of the next calendar day after the incident:

1. The staff member’s supervisor.
2. The consumer or the consumer’s legal guardian. EXCEPTION: Notification to the consumer is required only if the incident took place outside of the provider’s service provision. Notification to the guardian, if any, is always required.
3. The consumer’s case manager.

(2) By the end of the next calendar day after the incident, the staff member who observed or first became aware of the incident shall also report as much information as is known about the incident to the department’s bureau of long-term care either:

1. By direct data entry into the Iowa Medicaid Provider Access System, or
2. By faxing or mailing Form 470-4698, Critical Incident Report, according to the directions on the form.

(3) The following information shall be reported:

1. The name of the consumer involved.
2. The date and time the incident occurred.
3. A description of the incident.
4. The names of all provider staff and others who were present at the time of the incident or who responded after becoming aware of the incident. The confidentiality of other waiver-eligible or non-waiver-eligible consumers who were present must be maintained by the use of initials or other means.
5. The action that the provider staff took to manage the incident.
6. The resolution of or follow-up to the incident.
7. The date the report is made and the handwritten or electronic signature of the person making the report.

(4) Submission of the initial report will generate a workflow in the Individualized Services Information System (ISIS) for follow-up by the case manager. When complete information about the incident is not available at the time of the initial report, the provider must submit follow-up reports until the case manager is satisfied with the incident resolution and follow-up. The completed report shall be maintained in a centralized file with a notation in the consumer's file.

d. Tracking and analysis. The provider shall track incident data and analyze trends to assess the health and safety of consumers served and determine if changes need to be made for service implementation or if staff training is needed to reduce the number or severity of incidents.

This rule is intended to implement Iowa Code section 249A.4.

[ARC 7936B, IAB 7/1/09, effective 9/1/09; ARC 9314B, IAB 12/29/10, effective 3/1/11; ARC 1149C, IAB 10/30/13, effective 1/1/14]

441—77.35(249A) Federally qualified health centers. Federally qualified health centers are eligible to participate in the Medicaid program when the Centers for Medicare and Medicaid Services has notified the Medicaid program of their eligibility as allowed by Section 6404(b) of Public Law 101-239.

This rule is intended to implement Iowa Code section 249A.4.

441—77.36(249A) Advanced registered nurse practitioners. Advanced registered nurse practitioners are eligible to participate in the Medicaid program if they are duly licensed and registered by the state of Iowa as advanced registered nurse practitioners certified pursuant to board of nursing rules 655—Chapter 7.

77.36(1) Advanced registered nurse practitioners in another state shall be eligible to participate if they are duly licensed and registered in that state as advanced registered nurse practitioners with certification in a practice area consistent with board of nursing rules 655—Chapter 7.

77.36(2) Advanced registered nurse practitioners who have been certified eligible to participate in Medicare shall be considered as having met these guidelines.

77.36(3) Licensed nurse anesthetists who have graduated from a nurse anesthesia program meeting the standards set forth by a national association of nurse anesthetists within the past 18 months and who are awaiting initial certification by a national association of nurse anesthetists approved by the board of nursing shall be considered as having met these guidelines.

This rule is intended to implement Iowa Code section 249A.4.

441—77.37(249A) Home- and community-based services intellectual disability waiver service providers. Providers shall be eligible to participate in the Medicaid HCBS intellectual disability waiver program if they meet the requirements in this rule and the subrules applicable to the individual service.

The standards in subrule 77.37(1) apply only to providers of supported employment, respite providers certified according to subparagraph 77.37(15)“a”(8), and providers of supported community living services that are not residential-based. The standards and certification processes in subrules

77.37(2) through 77.37(7) and 77.37(9) through 77.37(12) apply only to supported employment providers and non-residential-based supported community living providers.

The requirements in subrule 77.37(13) apply to all providers. EXCEPTION: A person hired through the consumer choices option for independent support brokerage, self-directed personal care, individual-directed goods and services, or self-directed community support and employment is not required to enroll as a Medicaid provider and is not subject to the review requirements in subrule 77.37(13). Also, services must be rendered by a person who is at least 16 years old (except as otherwise provided in this rule) and is not the spouse of the consumer served or the parent or stepparent of a consumer aged 17 or under. People who are 16 or 17 years old must be employed and supervised by an enrolled HCBS provider unless they are employed to provide self-directed personal care services through the consumer choices option. A person hired for self-directed personal care services need not be supervised by an enrolled HCBS provider. Consumer-directed attendant care and interim medical monitoring and treatment providers must be at least 18 years of age.

77.37(1) Organizational standards (Outcome 1). Organizational outcome-based standards for home- and community-based services intellectual disability providers are as follows:

a. The organization demonstrates the provision and oversight of high-quality supports and services to consumers.

b. The organization demonstrates a defined mission commensurate with consumer's needs, desires, and abilities.

c. The organization establishes and maintains fiscal accountability.

d. The organization has qualified staff commensurate with the needs of the consumers they serve. These staff demonstrate competency in performing duties and in all interactions with clients.

e. The organization provides needed training and supports to its staff. This training includes at a minimum:

(1) Consumer rights.

(2) Confidentiality.

(3) Provision of consumer medication.

(4) Identification and reporting of child and dependent adult abuse.

(5) Individual consumer support needs.

f. The organization has a systematic, organizationwide, planned approach to designing, measuring, evaluating, and improving the level of its performance. The organization:

(1) Measures and assesses organizational activities and services annually.

(2) Gathers information from consumers, family members, and staff.

(3) Conducts an internal review of consumer service records, including all major and minor incident reports according to subrule 77.37(8).

(4) Tracks incident data and analyzes trends annually to assess the health and safety of consumers served by the organization.

(5) Identifies areas in need of improvement.

(6) Develops a plan to address the areas in need of improvement.

(7) Implements the plan and documents the results.

g. Consumers and their legal representatives have the right to appeal the provider's implementation of the 20 outcomes, or staff or contractual person's action which affects the consumer. The provider shall distribute the policies for consumer appeals and procedures to consumers.

h. The provider shall have written policies and procedures and a staff training program for the identification and reporting of child and dependent adult abuse to the department pursuant to 441—Chapters 175 and 176.

i. The governing body has an active role in the administration of the agency.

j. The governing body receives and uses input from a wide range of local community interests and consumer representation and provides oversight that ensures the provision of high-quality supports and services to consumers.

77.37(2) Rights and dignity. Outcome-based standards for rights and dignity are as follows:

a. (Outcome 2) Consumers are valued.

- b. (Outcome 3) Consumers live in positive environments.
- c. (Outcome 4) Consumers work in positive environments.
- d. (Outcome 5) Consumers exercise their rights and responsibilities.
- e. (Outcome 6) Consumers have privacy.
- f. (Outcome 7) When there is a need, consumers have support to exercise and safeguard their rights.
- g. (Outcome 8) Consumers decide which personal information is shared and with whom.
- h. (Outcome 9) Consumers make informed choices about where they work.
- i. (Outcome 10) Consumers make informed choices on how they spend their free time.
- j. (Outcome 11) Consumers make informed choices about where and with whom they live.
- k. (Outcome 12) Consumers choose their daily routine.
- l. (Outcome 13) Consumers are a part of community life and perform varied social roles.
- m. (Outcome 14) Consumers have a social network and varied relationships.
- n. (Outcome 15) Consumers develop and accomplish personal goals.
- o. (Outcome 16) Management of consumers' money is addressed on an individualized basis.
- p. (Outcome 17) Consumers maintain good health.
- q. (Outcome 18) The consumer's living environment is reasonably safe in the consumer's home and community.
- r. (Outcome 19) The consumer's desire for intimacy is respected and supported.
- s. (Outcome 20) Consumers have an impact on the services they receive.

77.37(3) *Contracts with consumers.* The provider shall have written procedures which provide for the establishment of an agreement between the consumer and the provider.

a. The agreement shall define the responsibilities of the provider and the consumer, the rights of the consumer, the services to be provided to the consumer by the provider, all room and board and copay fees to be charged to the consumer and the sources of payment.

b. Contracts shall be reviewed at least annually.

77.37(4) *The right to appeal.* Consumers and their legal representatives have the right to appeal the provider's application of policies or procedures, or any staff or contractual person's action which affects the consumer. The provider shall distribute the policies for consumer appeals and procedures to consumers.

77.37(5) *Storage and provision of medication.* If the provider stores, handles, prescribes, dispenses or administers prescription or over-the-counter medications, the provider shall develop procedures for the storage, handling, prescribing, dispensing or administration of medication. For controlled substances, procedures shall be in accordance with department of inspections and appeals rule 481—63.18(135).

If the provider has a physician on staff or under contract, the physician shall review and document the provider's prescribed medication regime at least annually in accordance with current medical practice.

77.37(6) *Research.* If the provider conducts research involving human subjects, the provider shall have written policies and procedures for research which ensure the rights of consumers and staff.

77.37(7) *Abuse reporting requirements.* The provider shall have written policies and procedures and a staff training program for the identification and reporting of child and dependent adult abuse to the department pursuant to 441—Chapters 175 and 176.

77.37(8) *Incident management and reporting.* As a condition of participation in the medical assistance program, HCBS intellectual disability waiver service providers must comply with the requirements of Iowa Code sections 232.69 and 235B.3 regarding the reporting of child abuse and dependent adult abuse and with the incident management and reporting requirements in this subrule. EXCEPTION: The conditions in this subrule do not apply to providers of goods and services purchased under the consumer choices option or providers of home and vehicle modification, personal emergency response, and transportation.

a. *Definitions.*

"Major incident" means an occurrence involving a consumer during service provision that:

1. Results in a physical injury to or by the consumer that requires a physician's treatment or admission to a hospital;

2. Results in the death of any person;
3. Requires emergency mental health treatment for the consumer;
4. Requires the intervention of law enforcement;
5. Requires a report of child abuse pursuant to Iowa Code section 232.69 or a report of dependent adult abuse pursuant to Iowa Code section 235B.3;
6. Constitutes a prescription medication error or a pattern of medication errors that leads to the outcome in paragraph “1,” “2,” or “3”; or
7. Involves a consumer’s location being unknown by provider staff who are assigned protective oversight.

“*Minor incident*” means an occurrence involving a consumer during service provision that is not a major incident and that:

1. Results in the application of basic first aid;
2. Results in bruising;
3. Results in seizure activity;
4. Results in injury to self, to others, or to property; or
5. Constitutes a prescription medication error.

b. *Reporting procedure for minor incidents.* Minor incidents may be reported in any format designated by the provider. When a minor incident occurs or a staff member becomes aware of a minor incident, the staff member involved shall submit the completed incident report to the staff member’s supervisor within 72 hours of the incident. The completed report shall be maintained in a centralized file with a notation in the consumer’s file.

c. *Reporting procedure for major incidents.* When a major incident occurs or a staff member becomes aware of a major incident:

(1) The staff member involved shall notify the following persons of the incident by the end of the next calendar day after the incident:

1. The staff consumer’s supervisor.
2. The consumer or the consumer’s legal guardian. EXCEPTION: Notification to the consumer is required only if the incident took place outside of the provider’s service provision. Notification to the guardian, if any, is always required.
3. The consumer’s case manager.

(2) By the end of the next calendar day after the incident, the staff member who observed or first became aware of the incident shall also report as much information as is known about the incident to the department’s bureau of long-term care either:

1. By direct data entry into the Iowa Medicaid Provider Access System, or
2. By faxing or mailing Form 470-4698, Critical Incident Report, according to the directions on the form.

(3) The following information shall be reported:

1. The name of the consumer involved.
2. The date and time the incident occurred.
3. A description of the incident.
4. The names of all provider staff and others who were present at the time of the incident or who responded after becoming aware of the incident. The confidentiality of other waiver-eligible or non-waiver-eligible consumers who were present must be maintained by the use of initials or other means.
5. The action that the provider staff took to manage the incident.
6. The resolution of or follow-up to the incident.
7. The date the report is made and the handwritten or electronic signature of the person making the report.

(4) Submission of the initial report will generate a workflow in the Individualized Services Information System (ISIS) for follow-up by the case manager. When complete information about the incident is not available at the time of the initial report, the provider must submit follow-up reports until

the case manager is satisfied with the incident resolution and follow-up. The completed report shall be maintained in a centralized file with a notation in the consumer's file.

d. Tracking and analysis. The provider shall track incident data and analyze trends to assess the health and safety of consumers served and determine if changes need to be made for service implementation or if staff training is needed to reduce the number or severity of incidents.

77.37(9) *Intake, admission, service coordination, discharge, and referral.*

a. The provider shall have written policies and procedures according to state and federal laws for intake, admission, service coordination, discharge and referral. Service coordination means activities designed to help individuals and families locate, access, and coordinate a network of supports and services that will allow them to live a full life in the community.

b. The provider shall ensure the rights of persons applying for services.

77.37(10) *Certification process.* Reviews of compliance with standards for initial certification and recertification shall be conducted by the department of human services' bureau of long-term care quality assurance staff. Certification carries no assurance that the approved provider will receive funding.

a. Rescinded IAB 9/1/04, effective 11/1/04.

b. Rescinded IAB 9/1/04, effective 11/1/04.

c. Rescinded IAB 9/1/04, effective 11/1/04.

d. The department may request any information from the prospective service provider which is considered pertinent to arriving at a certification decision. This may include, but is not limited to:

(1) Current accreditations, evaluations, inspections and reviews by regulatory and licensing agencies and associations.

(2) Fiscal capacity of the prospective provider to initiate and operate the specified programs on an ongoing basis.

77.37(11) *Initial certification.* The department shall review the application and accompanying information to see if the provider has the necessary framework to provide services in accordance with all applicable requirements and standards.

a. The department shall make a determination regarding initial certification within 60 days of receipt of the application and notify the provider in writing of the decision unless extended by mutual consent of the parties involved. Providers shall be responsible for notifying the appropriate county and the appropriate central point of coordination of the determination.

b. The decision of the department on initial certification of the providers shall be based on all relevant information, including:

(1) The application for status as an approved provider according to requirements of rules.

(2) A determination of the financial position of the prospective provider in relation to its ability to meet the stated need.

(3) The prospective provider's coordination of service design, development, and application with the applicable region and other interested parties.

(4) The prospective provider's written agreement to work cooperatively with the state, counties and regions to be served by the provider.

c. Providers applying for initial certification shall be offered technical assistance.

77.37(12) *Period of certification.* Provider certification shall become effective on the date identified on the certificate of approval and shall terminate in 270 calendar days, one year, or three calendar years from the month of issue. The renewal of certification shall be contingent upon demonstration of continued compliance with certification requirements.

a. Initial certification. Providers eligible for initial certification by the department shall be issued an initial certification for 270 calendar days based on documentation provided.

b. Recertification. After the initial certification, the level of certification shall be based on an on-site review unless the provider has been accredited for similar services by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), the Commission on Accreditation of Rehabilitation Facilities (CARF), the Council on Quality and Leadership in Supports for People with Disabilities (The Council), or the Council on Accreditation of Services for Families and Children (COA). The on-site reviews for supported community living and supported employment use interviews with consumers and

significant people in the consumer's life to determine whether or not the 20 individual value-based outcomes set forth in subrules 77.37(1) and 77.37(2) and corresponding processes are present for the consumer. Respite services are required to meet Outcome 1 and participate in satisfaction surveys.

Once the outcomes and processes have been determined for all the consumers in the sample, a review team then determines which of the 20 outcomes and processes are present for the provider. A specific outcome is present for the provider when the specific outcome is determined to be present for 75 percent or more of the consumers interviewed. A specific process is present for the provider when the process is determined to be present for 75 percent or more of the consumers interviewed. Since the processes are in the control of the provider and the outcomes are more in the control of the consumer, length of certification will be based more heavily on whether or not the processes are in place to help consumers obtain desired outcomes.

An exit conference shall be held with the organization to share preliminary findings of the certification review. A review report shall be written and sent to the provider within 30 calendar days unless the parties mutually agree to extend that time frame.

Provider certification shall become effective on the date identified on the Certificate of Approval, Form 470-3410, and shall terminate in 270 calendar days, one year, or three calendar years from the month of issue. The renewal of certification shall be contingent upon demonstration of continued compliance with certification requirements.

c. The department may issue four categories of recertification:

(1) Three-year certification with excellence. An organization is eligible for certification with excellence if the number of processes present is 18 or higher and the number of outcomes and corresponding processes present together is 12 or higher. Both criteria need to be met to receive three-year certification with excellence. Corrective actions may be required which may be monitored through the assignment of follow-up monitoring either by written report, a plan of corrective actions and improvements, an on-site review, or the provision of technical assistance.

(2) Three-year certification with follow-up monitoring. An organization is eligible for this type of certification if the number of processes present is 17 or higher and the number of outcomes and corresponding processes present together are 11 or higher. Both criteria need to be met to receive three-year certification. Corrective actions are required which may be monitored through the assignment of follow-up monitoring either by written report, a plan of corrective actions and improvements, an on-site review, or the provision of technical assistance.

(3) One-year certification. An organization is eligible for this type of certification when the number of processes present is 14 or higher and the number of outcomes and processes together is 9 or higher. Both criteria need to be met to receive one-year certification. One-year certification may also be given in lieu of longer certification when previously required corrective actions have not been implemented or completed. Corrective actions are required which may be monitored through the assignment of follow-up monitoring either by written report, a plan of corrective actions and improvements, an on-site review, or the provision of technical assistance.

(4) Probational certification. A probational certification may be issued to those providers who cannot meet requirements for a one-year certification. This time period shall be granted to the provider to establish and implement corrective actions and improvement activities. During this time period the department may require monitoring of the implementation of the corrective actions through on-site visits, written reports or technical assistance. Probational certification issued for 270 calendar days shall not be renewed or extended, and shall require a full on-site follow-up review to be completed. The provider shall be required to achieve at least a one-year certification status at the time of the follow-up review in order to maintain certification.

d. During the course of the review, if a team member encounters a situation that places a member in immediate jeopardy, the team member shall immediately notify the provider, the department, and other team members. "Immediate jeopardy" refers to circumstances where the life, health, or safety of a member will be severely jeopardized if the circumstances are not immediately corrected.

(1) The provider shall correct the situation within 24 to 48 hours. If the situation is not corrected within the prescribed time frame, that portion of the provider's services that was the subject of the

notification shall not be certified. The department shall be notified immediately to discontinue funding for that provider's service. If a member is in immediate jeopardy, the case manager or department service worker shall notify the county or region in the event the county or region is funding a service that may assist the member in the situation.

(2) If this action is appealed and the member, legal guardian, or attorney in fact under a durable power of attorney for health care wants to maintain the provider's services, funding can be reinstated. At that time the provider shall take appropriate action to ensure the life, health, and safety of the members deemed to be at risk as a result of the provider's inaction.

e. As a mandatory reporter, each team member shall be required to follow appropriate procedure in all cases where a condition reportable to child and adult protective services is observed.

f. The department may grant an extension to the period of approval for the following reasons:

(1) A delay in the department's approval decision which is beyond the control of the provider or department.

(2) A request for an extension from a provider to permit the provider to prepare and obtain department approval of corrective actions. The department shall establish the length of extensions on a case-by-case basis.

g. The department may revoke the provider's approval at any time for any of the following reasons:

(1) Findings of a site visit indicate that the provider has failed to implement the corrective actions submitted pursuant to paragraph 77.37(13)"*e.*"

(2) The provider has failed to provide information requested pursuant to paragraph 77.37(13)"*f.*"

(3) The provider refuses to allow the department to conduct a site visit pursuant to paragraph 77.37(13)"*h.*"

(4) There are instances of noncompliance with the standards which were not identified from information submitted on the application.

h. An approved provider shall immediately notify the department, applicable county, or region, the applicable mental health and developmental disabilities planning council, and other interested parties of a decision to withdraw from a home- and community-based services intellectual disability waiver service.

i. Following certification, any provider may request technical assistance from the department to bring into conformity those areas found in noncompliance with HCBS requirements. If multiple deficiencies are noted during a review, the department may require that technical assistance be provided to a provider to assist in the implementation of the provider's corrective actions. Providers may be given technical assistance as needed.

j. Appeals. Any adverse action can be appealed by the provider under 441—Chapter 7.

77.37(13) Review of providers. Reviews of compliance with standards as indicated in this chapter shall be conducted by designated members of the HCBS staff.

a. This review may include on-site case record audits; review of administrative procedures, clinical practices, personnel records, performance improvement systems and documentation; and interviews with staff, consumers, the board of directors, or others deemed appropriate, consistent with the confidentiality safeguards of state and federal laws.

b. A review visit shall be scheduled with the provider with additional reviews conducted at the discretion of the department.

c. The on-site review team will consist of designated members of the HCBS staff.

d. Following a certification review, the certification review team leader shall submit a copy of the department's written report of findings to the provider within 30 working days after completion of the certification review.

e. The provider shall develop a plan of corrective action, if applicable, identifying completion time frames for each review recommendation.

f. Providers required to make corrective actions and improvements shall submit the corrective action and improvement plan to the Bureau of Long-Term Care, 1305 East Walnut Street, Des Moines, Iowa 50319-0114, within 30 working days after the receipt of a report issued as a result of the review team's visit. The corrective actions may include: specific problem areas cited, corrective actions to be

implemented by the provider, dates by which each corrective measure will be completed, and quality assurance and improvement activities to measure and ensure continued compliance.

g. The department may request the provider to supply subsequent reports on implementation of a corrective action plan submitted pursuant to 77.37(13)“e” and 77.37(13)“f.”

h. The department may conduct a site visit to verify all or part of the information submitted.

77.37(14) Supported community living providers.

a. The department will contract only with public or private agencies to provide the supported community living service. The department does not recognize individuals as service providers under the supported community living program.

b. Providers of services meeting the definition of foster care shall also be licensed according to applicable 441—Chapters 108, 112, 114, 115, and 116.

c. Providers of service may employ or contract with individuals meeting the definition of foster family homes to provide supported community living services. These individuals shall be licensed according to applicable 441—Chapters 112 and 113.

d. All supported community living providers shall meet the following requirements:

(1) The provider shall demonstrate how the provider will meet the outcomes and processes in rule 441—77.37(249A) for each of the consumers being served. The provider shall supply timelines showing how the provider will come into compliance with rules 441—77.37(249A), 441—78.41(249A), and 441—83.60(249A) to 441—83.70(249A) and 441—subrule 79.1(15) within one year of certification. These timelines shall include:

1. Implementation of necessary staff training and consumer input.
2. Implementation of provider system changes to allow for flexibility in staff duties, services based on what each individual needs, and removal of housing as part of the service.

(2) The provider shall demonstrate that systems are in place to measure outcomes and processes for individual consumers before certification can be given.

e. The department shall approve living units designed to serve up to four persons except as necessary to prevent an overconcentration of supported community living units in a geographic area.

f. The department shall approve a living unit designed to serve five persons if both of the following conditions are met:

(1) Approval will not result in an overconcentration of supported community living units in a geographic area.

(2) The county in which the living unit is located provides to the bureau of long-term care verification in writing that the approval is needed to address one or more of the following issues:

1. The quantity of services currently available in the county is insufficient to meet the need;
2. The quantity of affordable rental housing in the county is insufficient to meet the need; or
3. Approval will result in a reduction in the size or quantity of larger congregate settings.

77.37(15) Respite care providers.

a. The following agencies may provide respite services:

(1) Group living foster care facilities for children licensed by the department according to 441—Chapters 112 and 114 to 116 and child care centers licensed according to 441—Chapter 109.

(2) Nursing facilities, intermediate care facilities for the mentally retarded, and hospitals enrolled as providers in the Iowa Medicaid program.

(3) Residential care facilities for persons with mental retardation licensed by the department of inspections and appeals.

(4) Home health agencies that are certified to participate in the Medicare program.

(5) Camps certified by the American Camping Association.

(6) Adult day care providers that meet the conditions of participation set forth in subrule 77.37(25).

(7) Agencies authorized to provide similar services through a contract with the department of public health (IDPH) for local public health services. The agency must provide a current IDPH local public health services contract number.

(8) Agencies certified by the department to provide respite services in the consumer’s home that meet the requirements of 77.37(1) and 77.37(3) through 77.37(9).

- (9) Assisted living programs certified by the department of inspections and appeals.
- b. Respite providers shall meet the following conditions:
 - (1) Providers shall maintain the following information that shall be updated at least annually:
 - 1. The consumer's name, birth date, age, and address and the telephone number of each parent, guardian or primary caregiver.
 - 2. An emergency medical care release.
 - 3. Emergency contact telephone numbers such as the number of the consumer's physician and the parents, guardian, or primary caregiver.
 - 4. The consumer's medical issues, including allergies.
 - 5. The consumer's daily schedule which includes the consumer's preferences in activities or foods or any other special concerns.

(2) Procedures shall be developed for the dispensing, storage, authorization, and recording of all prescription and nonprescription medications administered. Home health agencies must follow Medicare regulations for medication dispensing.

All medications shall be stored in their original containers, with the accompanying physician's or pharmacist's directions and label intact. Medications shall be stored so they are inaccessible to consumers and the public. Nonprescription medications shall be labeled with the consumer's name.

In the case of medications that are administered on an ongoing, long-term basis, authorization shall be obtained for a period not to exceed the duration of the prescription.

- (3) Policies shall be developed for:
 - 1. Notifying the parent, guardian or primary caregiver of any injuries or illnesses that occur during respite provision. A parent's, guardian's or primary caregiver's signature is required to verify receipt of notification.
 - 2. Requiring the parent, guardian or primary caregiver to notify the respite provider of any injuries or illnesses that occurred prior to respite provision.
 - 3. Documenting activities and times of respite. This documentation shall be made available to the parent, guardian or primary caregiver upon request.
 - 4. Ensuring the safety and privacy of the individual. Policies shall at a minimum address threat of fire, tornado, or flood and bomb threats.

c. A facility providing respite under this subrule shall not exceed the facility's licensed capacity, and services shall be provided in locations consistent with licensure.

d. Respite provided outside the consumer's home or the facility covered by the licensure, certification, accreditation, or contract must be approved by the parent, guardian or primary caregiver and the interdisciplinary team and must be consistent with the way the location is used by the general public. Respite in these locations shall not exceed 72 continuous hours.

77.37(16) Supported employment providers.

- a. The following agencies may provide supported employment services:
 - (1) An agency that is accredited by the Commission on Accreditation of Rehabilitation Facilities as an organizational employment service provider, a community employment service provider, or a provider of a similar service.
 - (2) An agency that is accredited by the Council on Accreditation of Services for Families and Children for similar services.
 - (3) An agency that is accredited by the Joint Commission on Accreditation of Healthcare Organizations for similar services.
 - (4) An agency that is accredited by the Council on Quality and Leadership in Supports for People with Disabilities for similar services.
 - (5) An agency that is accredited by the International Center for Clubhouse Development.
- b. Providers responsible for the payroll of members shall have policies that ensure compliance with state and federal labor laws and regulations, which include, but are not limited to:
 - (1) Member vacation, sick leave and holiday compensation.
 - (2) Procedures for payment schedules and pay scale.
 - (3) Procedures for provision of workers' compensation insurance.

(4) Procedures for the determination and review of commensurate wages.

c. The department will contract only with public or private agencies to provide supported employment services. The department does not recognize individuals as service providers under the supported employment program.

77.37(17) Home and vehicle modification providers. The following providers may provide home and vehicle modification:

a. Providers certified to participate as supported community living service providers under the home- and community-based services intellectual disability or brain injury waiver.

b. Providers eligible to participate as home and vehicle modification providers under the elderly or health and disability waiver, enrolled as home and vehicle modification providers under the physical disability waiver, or certified as home and vehicle modification providers under the brain injury waiver.

c. Community businesses that have all necessary licenses and permits to operate in conformity with federal, state, and local laws and regulations and that submit verification of current liability and workers' compensation insurance.

77.37(18) Personal emergency response system providers. Personal emergency response system providers shall be agencies which meet the conditions of participation set forth in subrule 77.33(2) to maintain certification.

77.37(19) Nursing providers. Nursing providers shall be agencies that are certified to participate in the Medicare program as home health agencies.

77.37(20) Home health aide providers. Home health aide providers shall be agencies which are certified to participate in the Medicare program as home health agencies and which have an HCBS agreement with the department.

77.37(21) Consumer-directed attendant care providers. The following providers may provide consumer-directed attendant care service:

a. An individual who contracts with the member to provide attendant care service and who is:

(1) At least 18 years of age.

(2) Qualified by training or experience to carry out the member's plan of care pursuant to the department-approved case plan or individual comprehensive plan.

(3) Not the spouse of the member or a parent or stepparent of a member aged 17 or under.

(4) Not the recipient of respite services paid through home- and community-based services on behalf of a member who receives home- and community-based services.

b. Agencies authorized to provide similar services through a contract with the department of public health (IDPH) for local public health services. The agency must provide a current IDPH local public health services contract number.

c. Home health agencies which are certified to participate in the Medicare program.

d. Chore providers subcontracting with area agencies on aging or with letters of approval from the area agencies on aging stating that the organization is qualified to provide chore services.

e. Community action agencies as designated in Iowa Code section 216A.93.

f. Providers certified under an HCBS waiver for supported community living.

g. Assisted living programs that are certified by the department of inspections and appeals under 481—Chapter 69.

h. Adult day service providers that are certified by the department of inspections and appeals under 481—Chapter 70.

77.37(22) Interim medical monitoring and treatment providers.

a. The following providers may provide interim medical monitoring and treatment services:

(1) Home health agencies certified to participate in the Medicare program.

(2) Supported community living providers certified according to subrule 77.37(14) or 77.39(13).

b. Staff requirements. Staff members providing interim medical monitoring and treatment services to members shall meet all of the following requirements:

(1) Be at least 18 years of age.

(2) Not be the spouse of the member or a parent or stepparent of the member if the member is aged 17 or under.

(3) Not be a usual caregiver of the member.

(4) Be qualified by training or experience to provide medical intervention or intervention in a medical emergency necessary to carry out the member's plan of care. The training or experience required must be determined by the member's usual caregivers and a licensed medical professional on the member's interdisciplinary team and must be documented in the member's service plan.

c. Service documentation. Providers shall maintain clinical and fiscal records necessary to fully disclose the extent of services furnished to members. Records shall specify by service date the procedures performed, together with information concerning progress of treatment.

77.37(23) *Residential-based supported community living service providers.*

a. The department shall contract only with public or private agencies to provide residential-based supported community living services.

b. Subject to the requirements of this rule, the following agencies may provide residential-based supported community living services:

(1) Agencies licensed as group living foster care facilities under 441—Chapter 114.

(2) Agencies licensed as residential facilities for mentally retarded children under 441—Chapter 116.

(3) Other agencies providing residential-based supported community living services that meet the following conditions:

1. The agency must provide orientation training on the agency's purpose, policies, and procedures within one month of hire or contracting for all employed and contracted treatment staff and must provide 24 hours of training during the first year of employment or contracting. The agency must also provide at least 12 hours of training per year after the first year of employment for all employed and contracted treatment staff. Annual training shall include, at a minimum, training on children's mental retardation and developmental disabilities services and children's mental health issues. Identification and reporting of child abuse shall be covered in training at least every five years, in accordance with Iowa Code section 232.69.

2. The agency must have standards for the rights and dignity of children that are age-appropriate. These standards shall include the following:

- Children, their families, and their legal representatives decide what personal information is shared and with whom.

- Children are a part of family and community life and perform varied social roles.
- Children have family connections, a social network, and varied relationships.
- Children develop and accomplish personal goals.
- Children are valued.
- Children live in positive environments.
- Children exercise their rights and responsibilities.
- Children make informed choices about how they spend their free time.
- Children choose their daily routine.

3. The agency must use methods of self-evaluation by which:

- Past performance is reviewed.
- Current functioning is evaluated.
- Plans are made for the future based on the review and evaluation.

4. The agency must have a governing body that receives and uses input from a wide range of local community interests and consumer representatives and provides oversight that ensures the provision of high-quality supports and services to children.

5. Children, their parents, and their legal representatives must have the right to appeal the service provider's application of policies or procedures or any staff person's action that affects the consumer. The service provider shall distribute the policies for consumer appeals and procedures to children, their parents, and their legal representatives.

c. As a condition of participation, all providers of residential-based supported community living services must have the following on file:

(1) Current accreditations, evaluations, inspections, and reviews by applicable regulatory and licensing agencies and associations.

(2) Documentation of the fiscal capacity of the provider to initiate and operate the specified programs on an ongoing basis.

(3) The provider's written agreement to work cooperatively with the department.

d. As a condition of participation, all providers of residential-based supported community living services must develop, review, and revise service plans for each child, as follows:

(1) The service plan shall be developed in collaboration with the social worker or case manager, child, family, and, if applicable, the foster parents, unless a treatment rationale for the lack of involvement of one of these parties is documented in the plan. The service provider shall document the dates and content of the collaboration on the service plan. The service provider shall provide a copy of the service plan to the family and the case manager, unless otherwise ordered by a court of competent jurisdiction.

(2) Initial service plans shall be developed after services have been authorized and within 30 calendar days of initiating services.

(3) The service plan shall identify the following:

1. Strengths and needs of the child.

2. Goals to be achieved to meet the needs of the child.

3. Objectives for each goal that are specific, measurable, and time-limited and include indicators of progress toward each goal.

4. Specific service activities to be provided to achieve the objectives.

5. The persons responsible for providing the services. When daily living and social skills development is provided in a group care setting, designation may be by job title.

6. Date of service initiation and date of individual service plan development.

7. Service goals describing how the child will be reunited with the child's family and community.

(4) Individuals qualified to provide all services identified in the service plan shall review the services identified in the service plan to ensure that the services are necessary, appropriate, and consistent with the identified needs of the child, as listed on Form 470-3273, Mental Retardation Functional Assessment Tool.

(5) The service worker or case manager shall review all service plans to determine progress toward goals and objectives 90 calendar days from the initiation of services and every 90 calendar days thereafter for the duration of the services.

At a minimum, the provider shall submit written reports to the service worker or case manager at six-month intervals and when changes to the service plan are needed.

(6) The individual service plan shall be revised when any of the following occur:

1. Service goals or objectives have been achieved.

2. Progress toward goals and objectives is not being made.

3. Changes have occurred in the identified service needs of the child, as listed on Form 470-3273, Mental Retardation Functional Assessment Tool.

4. The service plan is not consistent with the identified service needs of the child, as listed in the service plan.

(7) The service plan shall be signed and dated by qualified staff of each reviewing provider after each review and revision.

(8) Any revisions of the service plan shall be made in collaboration with the child, family, case manager, and, if applicable, the foster parents and shall reflect the needs of the child. The service provider shall provide a copy of the revised service plan to the family and case manager, unless otherwise ordered by a court of competent jurisdiction.

e. The residential-based supportive community living service provider shall also furnish residential-based living units for all recipients of the residential-based supported community living services. Except as provided herein, living units provided may be of no more than four beds. Service providers who receive approval from the bureau of long-term care may provide living units of up to eight beds. The bureau shall approve five- to eight-bed living units only if all of the following conditions are met:

- (1) Rescinded IAB 8/7/02, effective 10/1/02.
- (2) There is a need for the service to be provided in a five- to eight-person living unit instead of a smaller living unit, considering the location of the programs in an area.
- (3) The provider supplies the bureau of long-term care with a written plan acceptable to the department that addresses how the provider will reduce its living units to four-bed units within a two-year period of time. This written plan shall include the following:
 1. How the transition will occur.
 2. What physical change will need to take place in the living units.
 3. How children and their families will be involved in the transitioning process.
 4. How this transition will affect children's social and educational environment.
 - f. Certification process and review of service providers.
- (1) The certification process for providers of residential-based supported community living services shall be pursuant to subrule 77.37(10).
- (2) The initial certification of residential-based supported community living services shall be pursuant to subrule 77.37(11).
- (3) Period and conditions of certification.
 1. Initial certification. Providers eligible for initial certification by the department shall be issued an initial certification for 270 calendar days, effective on the date identified on the certificate of approval, based on documentation provided.
 2. Recertification. After the initial certification, recertification shall be based on an on-site review and shall be contingent upon demonstration of compliance with certification requirements.

An exit conference shall be held with the provider to share preliminary findings of the recertification review. A review report shall be written and sent to the provider within 30 calendar days unless the parties mutually agree to extend that time frame.

Recertification shall become effective on the date identified on the Certificate of Approval, Form 470-3410, and shall terminate one year from the month of issuance.

Corrective actions may be required in connection with recertification and may be monitored through the assignment of follow-up monitoring either by written report, a plan of corrective actions and improvements, an on-site review, or the provision of technical assistance.
 3. Probational certification. Probational certification for 270 calendar days may be issued to a provider who cannot demonstrate compliance with all certification requirements on recertification review to give the provider time to establish and implement corrective actions and improvement activities.

During the probational certification period, the department may require monitoring of the implementation of the corrective actions through on-site visits, written reports, or technical assistance.

Probational certification shall not be renewed or extended and shall require a full on-site follow-up review to be completed. The provider must demonstrate compliance with all certification requirements at the time of the follow-up review in order to maintain certification.
 4. Immediate jeopardy. If, during the course of any review, a review team member encounters a situation that places a member in immediate jeopardy, the team member shall immediately notify the provider, the department, and other team members. "Immediate jeopardy" refers to circumstances where the life, health, or safety of a member will be severely jeopardized if the circumstances are not immediately corrected.

The provider shall correct the situation within 24 to 48 hours. If the situation is not corrected within the prescribed time frame, the provider shall not be certified. The department shall immediately discontinue funding for that provider's service. If this action is appealed and the member or legal guardian wants to maintain the provider's services, funding can be reinstated. At that time the provider shall take appropriate action to ensure the life, health, and safety of the members deemed to be at risk. The case manager or department service worker shall notify the county or region in the event the county or region is funding a service that may assist the member in the situation.
 5. Abuse reporting. As a mandatory reporter, each review team member shall follow appropriate procedure in all cases where a condition reportable to child and adult protective services is observed.

6. Extensions. The department shall establish the length of extensions on a case-by-case basis. The department may grant an extension to the period of certification for the following reasons:

- A delay in the department's approval decision exists which is beyond the control of the provider or department.
- A request for an extension is received from a provider to permit the provider to prepare and obtain department approval of corrective actions.

7. Revocation. The department may revoke the provider's approval at any time for any of the following reasons:

- The findings of a site visit indicate that the provider has failed to implement the corrective actions submitted pursuant to paragraph 77.37(13) "e" and numbered paragraph 77.37(23) "f"(3) "4."
- The provider has failed to provide information requested pursuant to paragraph 77.37(13) "f" and numbered paragraph 77.37(23) "f"(3) "4."
- The provider refuses to allow the department to conduct a site visit pursuant to paragraph 77.37(13) "h" and subparagraph 77.37(23) "f"(3).
- There are instances of noncompliance with the standards that were not identified from information submitted on the application.

8. Notice of intent to withdraw. An approved provider shall immediately notify the department, applicable county, the applicable mental health and developmental disabilities planning council, and other interested parties of a decision to withdraw as a provider of residential-based supported community living services.

9. Technical assistance. Following certification, any provider may request technical assistance from the department regarding compliance with program requirements. The department may require that technical assistance be provided to a provider to assist in the implementation of any corrective action plan.

10. Appeals. The provider can appeal any adverse action under 441—Chapter 7.

(4) Providers of residential-based supported community living services shall be subject to reviews of compliance with program requirements pursuant to subrule 77.37(13).

77.37(24) *Transportation service providers.* The following providers may provide transportation:

- a. Accredited providers of home- and community-based services.
- b. Regional transit agencies as recognized by the Iowa department of transportation.
- c. Transportation providers that contract with county governments.
- d. Community action agencies as designated in Iowa Code section 216A.93.
- e. Nursing facilities licensed under Iowa Code chapter 135C.
- f. Area agencies on aging as designated in rule 17—4.4(231), subcontractors of area agencies on aging, or organizations with letters of approval from the area agencies on aging stating that the organization is qualified to provide transportation services.
- g. Transportation providers contracting with the nonemergency medical transportation contractor.

77.37(25) *Adult day care providers.* Adult day care providers shall be agencies that are certified by the department of inspections and appeals as being in compliance with the standards for adult day services programs at 481—Chapter 70.

77.37(26) *Prevocational services providers.* Providers of prevocational services must be accredited by one of the following:

- a. The Commission on Accreditation of Rehabilitation Facilities as a work adjustment service provider or an organizational employment service provider.
- b. The Council on Quality and Leadership.

77.37(27) *Day habilitation providers.* Day habilitation services may be provided by:

- a. Agencies accredited by the Commission on Accreditation of Rehabilitation Facilities to provide services that qualify as day habilitation under 441—subrule 78.41(14).
- b. Agencies accredited by the Commission on Accreditation of Rehabilitation Facilities to provide other services that began providing services that qualify as day habilitation under 441—subrule 78.41(14) since their last accreditation survey. The agency may provide day habilitation services until the current

accreditation expires. When the current accreditation expires, the agency must qualify under paragraph “a” or “d.”

c. Agencies not accredited by the Commission on Accreditation of Rehabilitation Facilities that have applied to the Commission within the last 12 months for accreditation to provide services that qualify as day habilitation under 441—subrule 78.41(14). An agency that has not received accreditation within 12 months after application to the Commission is no longer a qualified provider.

d. Agencies accredited by the Council on Quality and Leadership.

e. Agencies that have applied to the Council on Quality and Leadership for accreditation within the last 12 months. An agency that has not received accreditation within 12 months after application to the Council is no longer a qualified provider.

77.37(28) *Financial management service.* Consumers who elect the consumer choices option shall work with a financial institution that meets the qualifications in subrule 77.30(13).

77.37(29) *Independent support brokerage.* Consumers who elect the consumer choices option shall work with an independent support broker who meets the qualifications in subrule 77.30(14).

77.37(30) *Self-directed personal care.* Consumers who elect the consumer choices option may choose to purchase self-directed personal care services from an individual or business that meets the requirements in subrule 77.30(15).

77.37(31) *Individual-directed goods and services.* Consumers who elect the consumer choices option may choose to purchase individual-directed goods and services from an individual or business that meets the requirements in subrule 77.30(16).

77.37(32) *Self-directed community supports and employment.* Consumers who elect the consumer choices option may choose to purchase self-directed community supports and employment from an individual or business that meets the requirements in subrule 77.30(17).

This rule is intended to implement Iowa Code section 249A.4.

[ARC 7936B, IAB 7/1/09, effective 9/1/09; ARC 9314B, IAB 12/29/10, effective 3/1/11; ARC 0191C, IAB 7/11/12, effective 7/1/12; ARC 0359C, IAB 10/3/12, effective 12/1/12; ARC 0757C, IAB 5/29/13, effective 8/1/13; ARC 1071C, IAB 10/2/13, effective 10/1/13; ARC 1149C, IAB 10/30/13, effective 1/1/14]

441—77.38(249A) *Assertive community treatment.* Services in the assertive community treatment (ACT) program shall be rendered by a multidisciplinary team composed of practitioners from the disciplines described in this rule. The team shall be under the clinical supervision of a psychiatrist. The program shall designate an individual team member who shall be responsible for administration of the program, including authority to sign documents and receive payment on behalf of the program.

77.38(1) *Minimum composition.* At a minimum, the team shall consist of a nurse, a mental health service provider, and a substance abuse treatment professional.

77.38(2) *Psychiatrists.* A psychiatrist on the team shall be a physician (MD or DO) who:

- a. Is licensed under 653—Chapter 9,
- b. Is certified as a psychiatrist by the American Board of Medical Specialties’ Board of Psychiatry and Neurology or by the American Osteopathic Board of Neurology and Psychiatry, and
- c. Has experience treating serious and persistent mental illness.

77.38(3) *Registered nurses.* A nurse on the team shall:

- a. Be licensed as a registered nurse under 655—Chapter 3, and
- b. Have experience treating persons with serious and persistent mental illness.

77.38(4) *Mental health service providers.* A mental health service provider on the team shall be:

- a. A mental health counselor or marital and family therapist who:
 - (1) Is licensed under 645—Chapter 31, and
 - (2) Has experience treating persons with serious and persistent mental illness; or
- b. A social worker who:
 - (1) Is licensed as a master or independent social worker under 645—Chapter 280, and
 - (2) Has experience treating persons with serious and persistent mental illness.

77.38(5) *Psychologists.* A psychologist on the team shall:

- a. Be licensed under 645—Chapter 240, and
- b. Have experience treating persons with serious and persistent mental illness.

77.38(6) Substance abuse treatment professionals. A substance abuse treatment professional on the team shall:

- a. Be an appropriately credentialed counselor pursuant to 641—paragraph 155.21(8) “i,” and
- b. Have at least three years of experience treating substance abuse.

77.38(7) Peer specialists. A peer specialist on the team shall be a person with serious and persistent mental illness who has met all requirements of a nationally standardized peer support training program, including at least 30 hours of training and satisfactory completion of an examination.

77.38(8) Community support specialists. A community support specialist on the team shall be a person who:

- a. Has a bachelor’s degree (BA or BS) in a human services field (sociology, social work, counseling, psychology, or human services), and
- b. Has experience supporting persons with serious and persistent mental illness.

77.38(9) Case managers. A case manager on the team shall be a person who:

- a. Has a bachelor’s degree (BA or BS) in a human services field (sociology, social work, counseling, psychology, or human services),
- b. Has experience managing care for persons with serious and persistent mental illness, and
- c. Meets the qualifications of “qualified case managers and supervisors” in rule 441—24.1(225C).

77.38(10) Advanced registered nurse practitioners. An advanced registered nurse practitioner on the team shall:

- a. Be licensed under 655—Chapter 7,
- b. Have a mental health certification, and
- c. Have experience treating serious and persistent mental illness.

77.38(11) Physician assistants. A physician assistant on the team shall:

- a. Be licensed under 645—Chapter 326,
- b. Have experience treating persons with serious and persistent mental illness, and
- c. Practice under the supervision of a psychiatrist.

This rule is intended to implement Iowa Code section 249A.4.

[ARC 9440B, IAB 4/6/11, effective 4/1/11]

441—77.39(249A) HCBS brain injury waiver service providers. Providers shall be eligible to participate in the Medicaid brain injury waiver program if they meet the requirements in this rule and the subrules applicable to the individual service. Beginning January 1, 2015, providers initially enrolling to deliver BI waiver services and each of their staff members involved in direct consumer service must have completed the department’s brain injury training modules one and two within 60 days from the beginning date of service provision, with the exception of staff members who are certified through the Academy of Certified Brain Injury Specialists (ACBIS) as a certified brain injury specialist (CBIS) or certified brain injury specialist trainer (CBIST), providers of home and vehicle modification, specialized medical equipment, transportation, personal emergency response, financial management, independent support brokerage, self-directed personal care, individual-directed goods and services, and self-directed community supports and employment. Providers enrolled to provide BI waiver services and each of their staff members involved in direct consumer service on or before December 31, 2014, shall be deemed to have completed the required training.

Services shall be rendered by a person who is at least 16 years old (except as otherwise provided in this rule) and is not the spouse of the consumer served or the parent or stepparent of a consumer aged 17 or under. People who are 16 or 17 years old must be employed and supervised by an enrolled HCBS provider unless they are employed to provide self-directed personal care services through the consumer choices option. A person hired for self-directed personal care services need not be supervised by an enrolled HCBS provider. A person hired through the consumer choices option for independent support brokerage, self-directed personal care, individual-directed goods and services, or self-directed community support and employment is not required to enroll as a Medicaid provider and is not subject to review under subrule 77.39(11). Consumer-directed attendant care and interim medical monitoring and treatment providers must be at least 18 years of age.

In addition, behavioral programming, supported community living, and supported employment providers shall meet the outcome-based standards set forth below in subrules 77.39(1) and 77.39(2) evaluated according to subrules 77.39(8) to 77.39(10), and the requirements of subrules 77.39(3) to 77.39(7). Respite providers shall also meet the standards in subrule 77.39(1).

77.39(1) *Organizational standards (Outcome 1).* Organizational outcome-based standards for HCBS BI providers are as follows:

a. The organization demonstrates the provision and oversight of high-quality supports and services to consumers.

b. The organization demonstrates a defined mission commensurate with consumers' needs, desires, and abilities.

c. The organization establishes and maintains fiscal accountability.

d. The organization has qualified staff commensurate with the needs of the consumers they serve. These staff demonstrate competency in performing duties and in all interactions with clients.

e. The organization provides needed training and supports to its staff. This training includes at a minimum:

(1) Consumer rights.

(2) Confidentiality.

(3) Provision of consumer medication.

(4) Identification and reporting of child and dependent adult abuse.

(5) Individual consumer support needs.

f. The organization has a systematic, organizationwide, planned approach to designing, measuring, evaluating, and improving the level of its performance. The organization:

(1) Measures and assesses organizational activities and services annually.

(2) Gathers information from consumers, family members, and staff.

(3) Conducts an internal review of consumer service records, including all major and minor incident reports according to subrule 77.37(8).

(4) Tracks incident data and analyzes trends annually to assess the health and safety of consumers served by the organization.

(5) Identifies areas in need of improvement.

(6) Develops a plan to address the areas in need of improvement.

(7) Implements the plan and documents the results.

g. Consumers and their legal representatives have the right to appeal the provider's implementation of the 20 outcomes, or staff or contractual person's action which affects the consumer. The provider shall distribute the policies for consumer appeals and procedures to consumers.

h. The provider shall have written policies and procedures and a staff training program for the identification and reporting of child and dependent adult abuse to the department pursuant to 441—Chapters 175 and 176.

i. The governing body has an active role in the administration of the agency.

j. The governing body receives and uses input from a wide range of local community interests and consumer representation and provides oversight that ensures the provision of high-quality supports and services to consumers.

77.39(2) *Rights and dignity.* Outcome-based standards for rights and dignity are as follows:

a. (Outcome 2) Consumers are valued.

b. (Outcome 3) Consumers live in positive environments.

c. (Outcome 4) Consumers work in positive environments.

d. (Outcome 5) Consumers exercise their rights and responsibilities.

e. (Outcome 6) Consumers have privacy.

f. (Outcome 7) When there is a need, consumers have support to exercise and safeguard their rights.

g. (Outcome 8) Consumers decide which personal information is shared and with whom.

h. (Outcome 9) Consumers make informed choices about where they work.

i. (Outcome 10) Consumers make informed choices on how they spend their free time.

- j. (Outcome 11) Consumers make informed choices about where and with whom they live.
- k. (Outcome 12) Consumers choose their daily routine.
- l. (Outcome 13) Consumers are a part of community life and perform varied social roles.
- m. (Outcome 14) Consumers have a social network and varied relationships.
- n. (Outcome 15) Consumers develop and accomplish personal goals.
- o. (Outcome 16) Management of consumers' money is addressed on an individualized basis.
- p. (Outcome 17) Consumers maintain good health.
- q. (Outcome 18) The consumer's living environment is reasonably safe in the consumer's home and community.
- r. (Outcome 19) The consumer's desire for intimacy is respected and supported.
- s. (Outcome 20) Consumers have an impact on the services they receive.

77.39(3) *The right to appeal.* Consumers and their legal representatives have the right to appeal the provider's application of policies or procedures, or any staff or contractual person's action which affects the consumer. The provider shall distribute the policies for consumer appeals and procedures to consumers.

77.39(4) *Storage and provision of medication.* If the provider stores, handles, prescribes, dispenses or administers prescription or over-the-counter medications, the provider shall develop procedures for the storage, handling, prescribing, dispensing or administration of medication. For controlled substances, procedures shall be in accordance with department of inspections and appeals rule 481—63.18(135).

77.39(5) *Research.* If the provider conducts research involving consumers, the provider shall have written policies and procedures addressing the research. These policies and procedures shall ensure that consumers' rights are protected.

77.39(6) *Incident management and reporting.* As a condition of participation in the medical assistance program, HCBS brain injury waiver service providers must comply with the requirements of Iowa Code sections 232.69 and 235B.3 regarding the reporting of child abuse and dependent adult abuse and with the incident management and reporting requirements in this subrule. **EXCEPTION:** The conditions in this subrule do not apply to providers of goods and services purchased under the consumer choices option or providers of home and vehicle modification, personal emergency response, and transportation.

a. Definitions.

"Major incident" means an occurrence involving a consumer during service provision that:

1. Results in a physical injury to or by the consumer that requires a physician's treatment or admission to a hospital;
2. Results in the death of any person;
3. Requires emergency mental health treatment for the consumer;
4. Requires the intervention of law enforcement;
5. Requires a report of child abuse pursuant to Iowa Code section 232.69 or a report of dependent adult abuse pursuant to Iowa Code section 235B.3;
6. Constitutes a prescription medication error or a pattern of medication errors that leads to the outcome in paragraph "1," "2," or "3"; or
7. Involves a consumer's location being unknown by provider staff who are assigned protective oversight.

"Minor incident" means an occurrence involving a consumer during service provision that is not a major incident and that:

1. Results in the application of basic first aid;
2. Results in bruising;
3. Results in seizure activity;
4. Results in injury to self, to others, or to property; or
5. Constitutes a prescription medication error.

b. Reporting procedure for minor incidents. Minor incidents may be reported in any format designated by the provider. When a minor incident occurs or a staff member becomes aware of a minor incident, the staff member involved shall submit the completed incident report to the staff member's

supervisor within 72 hours of the incident. The completed report shall be maintained in a centralized file with a notation in the consumer's file.

c. Reporting procedure for major incidents. When a major incident occurs or a staff member becomes aware of a major incident:

(1) The staff member involved shall notify the following persons of the incident by the end of the next calendar day after the incident:

1. The staff member's supervisor.

2. The consumer or the consumer's legal guardian. EXCEPTION: Notification to the consumer is required only if the incident took place outside of the provider's service provision. Notification to the guardian, if any, is always required.

3. The consumer's case manager.

(2) By the end of the next calendar day after the incident, the staff member who observed or first became aware of the incident shall also report as much information as is known about the incident to the department's bureau of long-term care either:

1. By direct data entry into the Iowa Medicaid Provider Access System, or

2. By faxing or mailing Form 470-4698, Critical Incident Report, according to the directions on the form.

(3) The following information shall be reported:

1. The name of the consumer involved.

2. The date and time the incident occurred.

3. A description of the incident.

4. The names of all provider staff and others who were present at the time of the incident or who responded after becoming aware of the incident. The confidentiality of other waiver-eligible or non-waiver-eligible consumers who were present must be maintained by the use of initials or other means.

5. The action that the provider staff took to manage the incident.

6. The resolution of or follow-up to the incident.

7. The date the report is made and the handwritten or electronic signature of the person making the report.

(4) Submission of the initial report will generate a workflow in the Individualized Services Information System (ISIS) for follow-up by the case manager. When complete information about the incident is not available at the time of the initial report, the provider must submit follow-up reports until the case manager is satisfied with the incident resolution and follow-up. The completed report shall be maintained in a centralized file with a notation in the consumer's file.

d. Tracking and analysis. The provider shall track incident data and analyze trends to assess the health and safety of consumers served and determine if changes need to be made for service implementation or if staff training is needed to reduce the number or severity of incidents.

77.39(7) *Intake, admission, service coordination, discharge, and referral.*

a. The provider shall have written policies and procedures according to state and federal laws for intake, admission, service coordination, discharge and referral.

b. The provider shall ensure the rights of persons applying for services.

77.39(8) *Certification process.* Reviews of compliance with standards for initial certification and recertification shall be conducted by the department of human services' bureau of long-term care quality assurance staff. Certification carries no assurance that the approved provider will receive funding.

a. Rescinded IAB 9/1/04, effective 11/1/04.

b. Rescinded IAB 9/1/04, effective 11/1/04.

c. Rescinded IAB 9/1/04, effective 11/1/04.

d. The department may request any information from the prospective service provider which is considered pertinent to arriving at a certification decision. This may include, but is not limited to:

(1) Current accreditations, evaluations, inspections and reviews by regulatory and licensing agencies and associations.

(2) Fiscal capacity of the prospective provider to initiate and operate the specified programs on an ongoing basis.

77.39(9) Initial certification. The department shall review the application and accompanying information to see if the provider has the necessary framework to provide services in accordance with all applicable requirements and standards.

a. The department shall make a determination regarding initial certification within 60 days of receipt of the application and notify the provider in writing of the decision unless extended by mutual consent of the parties involved.

b. The decision of the department on initial certification of the providers shall be based on all relevant information, including:

(1) The application for status as an approved provider according to requirements of rules.

(2) A determination of the financial position of the prospective provider in relation to its ability to meet the stated need.

c. Providers applying for initial certification shall be offered technical assistance.

77.39(10) Period of certification. Provider certification shall become effective on the date identified on the certificate of approval and shall terminate in 270 calendar days, one year, or three calendar years from the month of issue. The renewal of certification shall be contingent upon demonstration of continued compliance with certification requirements.

a. Initial certification. Providers eligible for initial certification by the department shall be issued an initial certification for 270 calendar days based on documentation provided.

b. Recertification. After the initial certification, the level of certification shall be based on an on-site review unless the provider has been accredited for similar services by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), the Commission on Accreditation of Rehabilitation Facilities (CARF), the Council on Quality and Leadership in Supports for People with Disabilities (The Council), or the Council on Accreditation of Services for Families and Children (COA). The on-site reviews for supported community living and supported employment use interviews with consumers and significant people in the consumer's life to determine whether or not the 20 individual value-based outcomes set forth in subrules 77.39(1) and 77.39(2) and corresponding processes are present for the consumer. Respite services are required to meet Outcome 1 and participate in satisfaction surveys.

Once the outcomes and processes have been determined for all the consumers in the sample, a review team then determines which of the 20 outcomes and processes are present for the provider. A specific outcome is present for the provider when the specific outcome is determined to be present for 75 percent or more of the consumers interviewed. A specific process is present for the provider when the process is determined to be present for 75 percent or more of the consumers interviewed. Since the processes are in the control of the provider and the outcomes are more in the control of the consumer, length of certification will be based more heavily on whether or not the processes are in place to help consumers obtain desired outcomes.

An exit conference shall be held with the organization to share preliminary findings of the certification review. A review report shall be written and sent to the provider within 30 calendar days unless the parties mutually agree to extend that time frame.

Provider certification shall become effective on the date identified on the Certificate of Approval, Form 470-3410, and shall terminate in 270 calendar days, one year, or three calendar years from the month of issue. The renewal of certification shall be contingent upon demonstration of continued compliance with certification requirements.

c. The department may issue four categories of recertification:

(1) *Three-year certification with excellence.* An organization is eligible for certification with excellence if the number of processes present is 18 or higher and the number of outcomes and corresponding processes present together is 12 or higher. Both criteria need to be met to receive three-year certification with excellence. Corrective actions may be required which may be monitored through the assignment of follow-up monitoring either by written report, a plan of corrective actions and improvements, an on-site review, or the provision of technical assistance.

(2) *Three-year certification with follow-up monitoring.* An organization is eligible for this type of certification if the number of processes present is 17 or higher and the number of outcomes and corresponding processes present together is 11 or higher. Both criteria need to be met to receive three-year certification. Corrective actions are required which may be monitored through the assignment of follow-up monitoring either by written report, a plan of corrective actions and improvements, an on-site review, or the provision of technical assistance.

(3) *One-year certification.* An organization is eligible for this type of certification when the number of processes present is 14 or higher and the number of outcomes and processes present together is 9 or higher. Both criteria need to be met to receive one-year certification. One-year certification may also be given in lieu of longer certification when previously required corrective actions have not been implemented or completed. Corrective actions are required which may be monitored through the assignment of follow-up monitoring either by written report, a plan of corrective actions and improvements, an on-site review, or the provision of technical assistance.

(4) *Probational certification.* A probational certification may be issued to those providers who cannot meet requirements for a one-year certification. This time period shall be granted to the provider to establish and implement corrective actions and improvement activities. During this time period the department may require monitoring of the implementation of the corrective actions through on-site visits, written reports or technical assistance. Probational certification issued for 270 calendar days shall not be renewed or extended and shall require a full on-site follow-up review to be completed. The provider shall be required to achieve at least a one-year certification status at the time of the follow-up review in order to maintain certification.

d. During the course of the review, if a team member encounters a situation that places a consumer in immediate jeopardy, the team member shall immediately notify the provider, the department, and other team members. "Immediate jeopardy" refers to circumstances where the life, health, or safety of a member will be severely jeopardized if the circumstances are not immediately corrected.

(1) The provider shall correct the situation within 24 to 48 hours. If the situation is not corrected within the prescribed time frame, that portion of the provider's services that was the subject of the notification shall not be certified. The department shall immediately discontinue funding for that provider's service.

(2) If this action is appealed and the member, legal guardian, or attorney in fact under a durable power of attorney for health care wants to maintain the provider's services, funding can be reinstated. At that time the provider shall take appropriate action to ensure the life, health, and safety of the members deemed to be at risk as a result of the provider's inaction.

e. As a mandatory reporter, each team member shall be required to follow appropriate procedure in all cases where a condition reportable to child and adult protective services is observed.

f. The department may grant an extension to the period of approval for the following reasons:

(1) A delay in the department's approval decision which is beyond the control of the provider or department.

(2) A request for an extension from a provider to permit the provider to prepare and obtain department approval of corrective actions. The department shall establish the length of extensions on a case-by-case basis.

g. The department may revoke the provider's approval at any time for any of the following reasons:

(1) Findings of a site visit indicate that the provider has failed to implement the corrective actions submitted pursuant to paragraph 77.39(11)"d."

(2) The provider has failed to provide information requested pursuant to paragraph 77.39(11)"e."

(3) The provider refuses to allow the department to conduct a site visit pursuant to paragraph 77.39(11)"f."

(4) There are instances of noncompliance with the standards which were not identified from information submitted on the application.

h. An approved provider shall immediately notify the department, applicable county, or region, the applicable mental health and developmental disabilities planning council, and other interested parties of a decision to withdraw from an HCBS BI waiver service.

i. Following certification, any provider may request technical assistance from the department to bring into conformity those areas found in noncompliance with HCBS requirements. If multiple deficiencies are noted during a review, the department may require that technical assistance be provided to a provider to assist in the implementation of the provider's corrective actions. Providers may be given technical assistance as needed.

j. Appeals. Any adverse action can be appealed by the provider under 441—Chapter 7.

77.39(11) Departmental reviews. Reviews of compliance with standards as indicated in this chapter shall be conducted by the division of mental health and developmental disabilities quality assurance review staff. This review may include on-site case record audits, administrative procedures, clinical practices, and interviews with staff, consumers, and board of directors consistent with the confidentiality safeguards of state and federal laws.

a. Reviews shall be conducted annually with additional reviews conducted at the discretion of the department.

b. Following a departmental review, the department shall submit a copy of the department's determined survey report to the service provider, noting service deficiencies and strengths.

c. The service provider shall develop a plan of corrective action identifying completion time frames for each survey deficiency.

d. The corrective action plan shall be submitted to the Division of Mental Health and Developmental Disabilities, 5th Floor, Hoover State Office Building, Des Moines, Iowa 50319-0114, and include a statement dated and signed, if applicable, by the chief administrative officer and president or chairperson of the governing body that all information submitted to the department is accurate and complete.

e. The department may request the provider to supply subsequent reports on implementation of a corrective action plan submitted pursuant to paragraphs 77.39(11) "*c*" and "*d*."

f. The department may conduct a site visit to verify all or part of the information submitted.

77.39(12) Case management service providers. Case management provider organizations are eligible to participate in the Medicaid HCBS brain injury waiver program provided that they meet the standards in 441—Chapter 24 and they are the department of human services, a county or consortium of counties, or a provider under subcontract to the department or a county or consortium of counties.

77.39(13) Supported community living providers.

a. The department shall certify only public or private agencies to provide the supported community living service. The department does not recognize individuals as service providers under the supported community living program.

b. Providers of services meeting the definition of foster care shall also be licensed according to applicable 441—Chapters 108, 112, 114, 115, and 116, which deal with foster care licensing.

c. Providers of service may employ or contract with individuals meeting the definition of foster family homes to provide supported community living services. These individuals shall be licensed according to applicable 441—Chapters 112 and 113, which deal with foster care licensing.

d. The department shall approve living units designed to serve four consumers if the geographic location of the program does not result in an overconcentration of programs in an area.

(1) and (2) Rescinded IAB 8/7/02, effective 10/1/02.

e. The department shall approve living units designed to serve up to four persons except as necessary to prevent an overconcentration of supported community living units in a geographic area.

f. The department shall approve a living unit designed to serve five persons if both of the following conditions are met:

(1) Approval will not result in an overconcentration of supported community living units in a geographic area.

(2) The county in which the living unit is located provides to the bureau of long-term care verification in writing that the approval is needed to address one or more of the following issues:

1. The quantity of services currently available in the county is insufficient to meet the need;
2. The quantity of affordable rental housing in the county is insufficient to meet the need; or
3. Approval will result in a reduction in the size or quantity of larger congregate settings.

77.39(14) *Respite service providers.* Respite providers are eligible to be providers of respite service in the HCBS brain injury waiver if they have documented training or experience with persons with a brain injury.

a. The following agencies may provide respite services:

- (1) Respite providers certified under the HCBS intellectual disability waiver.
- (2) Adult day care providers that meet the conditions of participation set forth in subrule 77.39(20).
- (3) Group living foster care facilities for children licensed by the department according to 441—Chapters 112 and 114 to 116 and child care centers licensed according to 441—Chapter 109.
- (4) Camps certified by the American Camping Association.
- (5) Home care agencies that meet the conditions of participation set forth in subrule 77.30(1).
- (6) Nursing facilities, intermediate care facilities for the mentally retarded, and hospitals enrolled as providers in the Iowa Medicaid program.
- (7) Residential care facilities for persons with mental retardation licensed by the department of inspections and appeals.
- (8) Home health agencies that are certified to participate in the Medicare program.
- (9) Agencies certified by the department to provide respite services in the consumer's home that meet the requirements of subrules 77.39(1) and 77.39(3) through 77.39(7).
- (10) Assisted living programs certified by the department of inspections and appeals.

b. Respite providers shall meet the following conditions:

- (1) Providers shall maintain the following information that shall be updated at least annually:
 1. The consumer's name, birth date, age, and address and the telephone number of each parent, guardian or primary caregiver.
 2. An emergency medical care release.
 3. Emergency contact telephone numbers such as the number of the consumer's physician and the parents, guardian, or primary caregiver.
 4. The consumer's medical issues, including allergies.
 5. The consumer's daily schedule which includes the consumer's preferences in activities or foods or any other special concerns.
- (2) Procedures shall be developed for the dispensing, storage, authorization, and recording of all prescription and nonprescription medications administered. Home health agencies must follow Medicare regulations for medication dispensing.

All medications shall be stored in their original containers, with the accompanying physician's or pharmacist's directions and label intact. Medications shall be stored so they are inaccessible to consumers and the public. Nonprescription medications shall be labeled with the consumer's name.

In the case of medications that are administered on an ongoing, long-term basis, authorization shall be obtained for a period not to exceed the duration of the prescription.

(3) Policies shall be developed for:

1. Notifying the parent, guardian or primary caregiver of any injuries or illnesses that occur during respite provision. A parent's, guardian's or primary caregiver's signature is required to verify receipt of notification.
2. Requiring the parent, guardian or primary caregiver to notify the respite provider of any injuries or illnesses that occurred prior to respite provision.
3. Documenting activities and times of respite. This documentation shall be made available to the parent, guardian or primary caregiver upon request.
4. Ensuring the safety and privacy of the individual. Policies shall at a minimum address threat of fire, tornado, or flood and bomb threats.

c. A facility providing respite under this subrule shall not exceed the facility's licensed capacity, and services shall be provided in locations consistent with licensure.

d. Respite provided outside the consumer's home or the facility covered by the licensure, certification, accreditation, or contract must be approved by the parent, guardian or primary caregiver and the interdisciplinary team and must be consistent with the way the location is used by the general public. Respite in these locations shall not exceed 72 continuous hours.

77.39(15) *Supported employment providers.*

a. The following agencies may provide supported employment services:

(1) An agency that is accredited by the Commission on Accreditation of Rehabilitation Facilities as an organizational employment service provider, a community employment service provider or a provider of a similar service.

(2) An agency that is accredited by the Council on Accreditation of Services for Families and Children for similar services.

(3) An agency that is accredited by the Joint Commission on Accreditation of Healthcare Organizations for similar services.

(4) An agency that is accredited by the Council on Quality and Leadership in Supports for People with Disabilities for similar services.

(5) An agency that is accredited by the International Center for Clubhouse Development.

b. Providers responsible for the payroll of members shall have policies that ensure compliance with state and federal labor laws and regulations, which include, but are not limited to:

(1) Member vacation, sick leave and holiday compensation.

(2) Procedures for payment schedules and pay scale.

(3) Procedures for provision of workers' compensation insurance.

(4) Procedures for the determination and review of commensurate wages.

c. The department will contract only with public or private agencies to provide supported employment services. The department does not recognize individuals as service providers under the supported employment program.

77.39(16) *Home and vehicle modification providers.* The following providers may provide home and vehicle modification:

a. Providers eligible to participate as home and vehicle modification providers under the elderly or health and disability waiver, enrolled as home and vehicle modification providers under the physical disability waiver, or certified as home and vehicle modification providers under the physical disability waiver.

b. Community businesses that have all necessary licenses and permits to operate in conformity with federal, state, and local laws and regulations and that submit verification of current liability and workers' compensation insurance.

77.39(17) *Personal emergency response system providers.* Personal emergency response system providers shall be agencies which meet the conditions of participation set forth in subrule 77.33(2).

a. Providers shall be certified annually.

b. The service provider shall submit documentation to the department supporting continued compliance with the requirements set forth in subrule 77.33(2) 90 days before the expiration of the current certification.

77.39(18) *Transportation service providers.* This service is not to be provided at the same time as supported community service, which includes transportation. The following providers may provide transportation:

a. Area agencies on aging as designated in rule 17—4.4(231) or with letters of approval from the area agencies on aging stating the organization is qualified to provide transportation services.

b. Community action agencies as designated in Iowa Code section 216A.93.

c. Regional transit agencies as recognized by the Iowa department of transportation.

d. Providers with purchase of service contracts to provide transportation pursuant to 441—Chapter 150.

e. Nursing facilities licensed pursuant to Iowa Code chapter 135C.

f. Transportation providers contracting with the nonemergency medical transportation contractor.

77.39(19) *Specialized medical equipment providers.* The following providers may provide specialized medical equipment:

a. Medical equipment and supply dealers participating as providers in the Medicaid program.

b. Retail and wholesale businesses participating as providers in the Medicaid program which provide specialized medical equipment as defined in 441—subrule 78.43(8).

77.39(20) *Adult day care providers.* Adult day care providers shall be agencies that are certified by the department of inspections and appeals as being in compliance with the standards for adult day services programs at 481—Chapter 70.

77.39(21) *Family counseling and training providers.* Family counseling and training providers shall be one of the following:

a. Providers certified under the community mental health center standards established by the mental health and developmental disabilities commission, set forth in 441—Chapter 24, Divisions I and III, and that employ staff to provide family counseling and training who meet the definition of qualified brain injury professional as set forth in rule 441—83.81(249A).

b. Providers licensed as meeting the hospice standards and requirements set forth in department of inspections and appeals rules in 481—Chapter 53 or certified to meet the standards under the Medicare program for hospice programs, and that employ staff who meet the definition of qualified brain injury professional as set forth in rule 441—83.81(249A).

c. Providers accredited under the mental health service provider standards established by the mental health and developmental disabilities commission, set forth in 441—Chapter 24, Divisions I and IV, and that employ staff to provide family counseling and training who meet the definition of qualified brain injury professional as set forth in rule 441—83.81(249A).

d. Individuals who meet the definition of qualified brain injury professional as set forth in rule 441—83.81(249A).

e. Agencies certified as brain injury waiver providers pursuant to rule 441—77.39(249A) that employ staff to provide family counseling who meet the definition of a qualified brain injury professional as set forth in rule 441—83.81(249A).

77.39(22) *Prevocational services providers.* Providers of prevocational services must meet the Commission on Accreditation of Rehabilitation Facilities standards for work adjustment service providers.

77.39(23) *Behavioral programming providers.* Behavioral programming providers shall be required to have experience with or training regarding the special needs of persons with a brain injury. In addition, they must meet the following requirements.

a. Behavior assessment, and development of an appropriate intervention plan, and periodic reassessment of the plan, and training of staff who shall implement the plan must be done by a qualified brain injury professional as defined in rule 441—83.81(249A). Formal assessment of the consumers' intellectual and behavioral functioning must be done by a licensed psychologist or a psychiatrist who is certified by the American Board of Psychiatry.

b. Implementation of the plan and training and supervision of caregivers, including family members, must be done by behavioral aides who have been trained by a qualified brain injury professional as defined in rule 441—83.81(249A) and who are employees of one of the following:

(1) Agencies which are certified under the community mental health center standards established by the mental health and developmental disabilities commission, set forth in 441—Chapter 24, Divisions I and III.

(2) Agencies which are licensed as meeting the hospice standards and requirements set forth in department of inspections and appeals rules 481—Chapter 53 or which are certified to meet the standards under the Medicare program for hospice programs.

(3) Agencies which are accredited under the mental health service provider standards established by the mental health and disabilities commission, set forth in 441—Chapter 24, Divisions I and IV.

(4) Home health aide providers meeting the standards set forth in subrule 77.33(3). Home health aide providers certified by Medicare shall be considered to have met these standards.

(5) Brain injury waiver providers certified pursuant to rule 441—77.39(249A).

77.39(24) *Consumer-directed attendant care providers.* The following providers may provide consumer-directed attendant care service:

a. An individual who contracts with the member to provide attendant care service and who is:

(1) At least 18 years of age.

(2) Qualified by training or experience to carry out the member's plan of care pursuant to the department-approved case plan or individual comprehensive plan.

(3) Not the spouse of the member or a parent or stepparent of a member aged 17 or under.

(4) Not the recipient of respite services paid through home- and community-based services on behalf of a member who receives home- and community-based services.

b. Agencies authorized to provide similar services through a contract with the department of public health (IDPH) for local public health services. The agency must provide a current IDPH local public health services contract number.

c. Home health agencies which are certified to participate in the Medicare program.

d. Chore providers subcontracting with area agencies on aging or with letters of approval from the area agencies on aging stating that the organization is qualified to provide chore services.

e. Community action agencies as designated in Iowa Code section 216A.93.

f. Providers certified under an HCBS waiver for supported community living.

g. Assisted living programs that are certified by the department of inspections and appeals under 481—Chapter 69.

h. Adult day service providers that are certified by the department of inspections and appeals under 481—Chapter 70.

77.39(25) *Interim medical monitoring and treatment providers.*

a. The following providers may provide interim medical monitoring and treatment services:

(1) Home health agencies certified to participate in the Medicare program.

(2) Supported community living providers certified according to subrule 77.37(14) or 77.39(13).

b. Staff requirements. Staff members providing interim medical monitoring and treatment services to members shall meet all of the following requirements:

(1) Be at least 18 years of age.

(2) Not be the spouse of the member or a parent or stepparent of the member if the member is aged 17 or under.

(3) Not be a usual caregiver of the member.

(4) Be qualified by training or experience to provide medical intervention or intervention in a medical emergency necessary to carry out the member's plan of care. The training or experience required must be determined by the member's usual caregivers and a licensed medical professional on the member's interdisciplinary team and must be documented in the member's service plan.

c. Service documentation. Providers shall maintain clinical and fiscal records necessary to fully disclose the extent of services furnished to members. Records shall specify by service date the procedures performed, together with information concerning progress of treatment.

77.39(26) *Financial management service.* Consumers who elect the consumer choices option shall work with a financial institution that meets the qualifications in subrule 77.30(13).

77.39(27) *Independent support brokerage.* Consumers who elect the consumer choices option shall work with an independent support broker who meets the qualifications in subrule 77.30(14).

77.39(28) *Self-directed personal care.* Consumers who elect the consumer choices option may choose to purchase self-directed personal care services from an individual or business that meets the requirements in subrule 77.30(15).

77.39(29) *Individual-directed goods and services.* Consumers who elect the consumer choices option may choose to purchase individual-directed goods and services from an individual or business that meets the requirements in subrule 77.30(16).

77.39(30) *Self-directed community supports and employment.* Consumers who elect the consumer choices option may choose to purchase self-directed community supports and employment from an individual or business that meets the requirements in subrule 77.30(17).

This rule is intended to implement Iowa Code section 249A.4.

[ARC 7936B, IAB 7/1/09, effective 9/1/09; ARC 9314B, IAB 12/29/10, effective 3/1/11; ARC 0191C, IAB 7/11/12, effective 7/1/12; ARC 0359C, IAB 10/3/12, effective 12/1/12; ARC 0757C, IAB 5/29/13, effective 8/1/13; ARC 1071C, IAB 10/2/13, effective 10/1/13; ARC 1149C, IAB 10/30/13, effective 1/1/14; ARC 1445C, IAB 4/30/14, effective 7/1/14; ARC 1638C, IAB 10/1/14, effective 11/5/14]

441—77.40(249A) Lead inspection agencies. The Iowa department of public health and agencies certified by the Iowa department of public health pursuant to 641—subrule 70.5(5) are eligible to participate in the Medicaid program as providers of lead inspection services.

This rule is intended to implement Iowa Code section 249A.4.

441—77.41(249A) HCBS physical disability waiver service providers. Providers shall be eligible to participate in the Medicaid physical disability waiver program if they meet the requirements in this rule and the subrules applicable to the individual service. Enrolled providers shall maintain the certification listed in the applicable subrules in order to remain eligible providers.

Services shall be rendered by a person who is at least 16 years old (except as otherwise provided in this rule) and is not the spouse of the consumer served or the parent or stepparent of a consumer aged 17 or under. People who are 16 or 17 years old must be employed and supervised by an enrolled HCBS provider unless they are employed to provide self-directed personal care services through the consumer choices option. A person hired for self-directed personal care services need not be supervised by an enrolled HCBS provider. A person hired through the consumer choices option for independent support brokerage, self-directed personal care, individual-directed goods and services, or self-directed community support and employment is not required to enroll as a Medicaid provider and is not subject to the requirements of subrule 77.41(1).

77.41(1) Enrollment process. Reviews of compliance with standards for initial enrollment shall be conducted by the department's quality assurance staff. Enrollment carries no assurance that the approved provider will receive funding.

Review of a provider may occur at any time.

The department may request any information from the prospective service provider that is pertinent to arriving at an enrollment decision. This may include, but is not limited to:

- a. Current accreditations, evaluations, inspection reports, and reviews by regulatory and licensing agencies and associations.
- b. Fiscal capacity of the prospective provider to initiate and operate the specified programs on an ongoing basis.

77.41(2) Consumer-directed attendant care providers. The following providers may provide consumer-directed attendant care service:

- a. An individual who contracts with the member to provide consumer-directed attendant care and who is:

- (1) At least 18 years of age.
- (2) Qualified by training or experience to carry out the member's plan of care pursuant to the department-approved case plan or individual comprehensive plan.
- (3) Not the spouse or guardian of the member or a parent or stepparent of a member aged 17 or under.
- (4) Not the recipient of respite services paid through home- and community-based services on behalf of a member who receives home- and community-based services.

- b. Agencies authorized to provide similar services through a contract with the department of public health (IDPH) for local public health services. The agency must provide a current IDPH local public health services contract number.

- c. Home health agencies that are certified to participate in the Medicare program.
- d. Chore providers subcontracting with area agencies on aging or with letters of approval from the area agencies on aging stating that the organization is qualified to provide chore services.
- e. Community action agencies as designated in Iowa Code section 216A.103.
- f. Providers certified under an HCBS waiver for supported community living.
- g. Assisted living programs that are certified by the department of inspections and appeals under 481—Chapter 69.
- h. Adult day service providers that are certified by the department of inspections and appeals under 481—Chapter 70.

77.41(3) Home and vehicle modification providers. The following providers may provide home and vehicle modifications:

a. Providers eligible to participate as home and vehicle modification providers under the elderly or health and disability waiver or certified as home and vehicle modification providers under the home- and community-based services intellectual disability or brain injury waiver.

b. Community businesses that have all necessary licenses and permits to operate in conformity with federal, state, and local laws and regulations and that submit verification of current liability and workers' compensation insurance.

77.41(4) Personal emergency response system providers. Personal emergency response system providers shall be agencies which meet the conditions of participation set forth in subrule 77.33(2).

77.41(5) Specialized medical equipment providers. The following providers may provide specialized medical equipment:

a. Medical equipment and supply dealers participating as providers in the Medicaid program.

b. Retail and wholesale businesses participating as providers in the Medicaid program which provide specialized medical equipment as defined in 441—subrule 78.46(4).

77.41(6) Transportation service providers. The following providers may provide transportation:

a. Area agencies on aging as designated in 17—4.4(231) or with letters of approval from the area agencies on aging stating the organization is qualified to provide transportation services.

b. Community action agencies as designated in Iowa Code section 216A.93.

c. Regional transit agencies as recognized by the Iowa department of transportation.

d. Nursing facilities licensed pursuant to Iowa Code chapter 135C.

e. Transportation providers contracting with the nonemergency medical transportation contractor.

77.41(7) Financial management service. Consumers who elect the consumer choices option shall work with a financial institution that meets the qualifications in subrule 77.30(13).

77.41(8) Independent support brokerage. Consumers who elect the consumer choices option shall work with an independent support broker who meets the qualifications in subrule 77.30(14).

77.41(9) Self-directed personal care. Consumers who elect the consumer choices option may choose to purchase self-directed personal care services from an individual or business that meets the requirements in subrule 77.30(15).

77.41(10) Individual-directed goods and services. Consumers who elect the consumer choices option may choose to purchase individual-directed goods and services from an individual or business that meets the requirements in subrule 77.30(16).

77.41(11) Self-directed community supports and employment. Consumers who elect the consumer choices option may choose to purchase self-directed community supports and employment from an individual or business that meets the subrule requirements in 77.30(17).

77.41(12) Incident management and reporting. As a condition of participation in the medical assistance program, HCBS physical disability waiver service providers must comply with the requirements of Iowa Code sections 232.69 and 235B.3 regarding the reporting of child abuse and dependent adult abuse and with the incident management and reporting requirements in this subrule. EXCEPTION: The conditions in this subrule do not apply to providers of goods and services purchased under the consumer choices option or providers of home and vehicle modification, specialized medical equipment, personal emergency response, and transportation.

a. Definitions.

“Major incident” means an occurrence involving a consumer during service provision that:

1. Results in a physical injury to or by the consumer that requires a physician's treatment or admission to a hospital;

2. Results in the death of any person;

3. Requires emergency mental health treatment for the consumer;

4. Requires the intervention of law enforcement;

5. Requires a report of child abuse pursuant to Iowa Code section 232.69 or a report of dependent adult abuse pursuant to Iowa Code section 235B.3;

6. Constitutes a prescription medication error or a pattern of medication errors that leads to the outcome in paragraph “1,” “2,” or “3”; or

7. Involves a consumer’s location being unknown by provider staff who are assigned protective oversight.

“*Minor incident*” means an occurrence involving a consumer during service provision that is not a major incident and that:

1. Results in the application of basic first aid;
2. Results in bruising;
3. Results in seizure activity;
4. Results in injury to self, to others, or to property; or
5. Constitutes a prescription medication error.

b. *Reporting procedure for minor incidents.* Minor incidents may be reported in any format designated by the provider. When a minor incident occurs or a staff member becomes aware of a minor incident, the staff member involved shall submit the completed incident report to the staff member’s supervisor within 72 hours of the incident. The completed report shall be maintained in a centralized file with a notation in the consumer’s file.

c. *Reporting procedure for major incidents.* When a major incident occurs or a staff member becomes aware of a major incident:

(1) The staff member involved shall notify the following persons of the incident by the end of the next calendar day after the incident:

1. The staff member’s supervisor.
2. The consumer or the consumer’s legal guardian. EXCEPTION: Notification to the consumer is required only if the incident took place outside of the provider’s service provision. Notification to the guardian, if any, is always required.
3. The consumer’s case manager.

(2) By the end of the next calendar day after the incident, the staff member who observed or first became aware of the incident shall also report as much information as is known about the incident to the department’s bureau of long-term care either:

1. By direct data entry into the Iowa Medicaid Provider Access System, or
2. By faxing or mailing Form 470-4698, Critical Incident Report, according to the directions on the form.

(3) The following information shall be reported:

1. The name of the consumer involved.
2. The date and time the incident occurred.
3. A description of the incident.
4. The names of all provider staff and others who were present at the time of the incident or who responded after becoming aware of the incident. The confidentiality of other waiver-eligible or non-waiver-eligible consumers who were present must be maintained by the use of initials or other means.
5. The action that the provider staff took to manage the incident.
6. The resolution of or follow-up to the incident.
7. The date the report is made and the handwritten or electronic signature of the person making the report.

(4) Submission of the initial report will generate a workflow in the Individualized Services Information System (ISIS) for follow-up by the case manager. When complete information about the incident is not available at the time of the initial report, the provider must submit follow-up reports until the case manager is satisfied with the incident resolution and follow-up. The completed report shall be maintained in a centralized file with a notation in the consumer’s file.

d. Tracking and analysis. The provider shall track incident data and analyze trends to assess the health and safety of consumers served and determine if changes need to be made for service implementation or if staff training is needed to reduce the number or severity of incidents.

This rule is intended to implement Iowa Code section 249A.4.

[ARC 7936B, IAB 7/1/09, effective 9/1/09; ARC 9314B, IAB 12/29/10, effective 3/1/11; ARC 0191C, IAB 7/11/12, effective 7/1/12; ARC 0359C, IAB 10/3/12, effective 12/1/12; ARC 0757C, IAB 5/29/13, effective 8/1/13; ARC 1071C, IAB 10/2/13, effective 10/1/13]

441—77.42(249A) Public health agencies. Public health agencies are eligible to participate in the medical assistance program when they serve as a public health entity within the local board of health jurisdiction pursuant to 641—subrule 77.3(3).

This rule is intended to implement Iowa Code section 249A.4.

[ARC 0358C, IAB 10/3/12, effective 11/7/12]

441—77.43(249A) Infant and toddler program providers. An agency is eligible to participate in the medical assistance program as a provider of infant and toddler program services under rule 441—78.49(249A) if the agency:

1. Is in good standing under the infants and toddlers with disabilities program administered by the department of education, the department of public health, the department of human services, and the Iowa Child Health Specialty Clinics pursuant to the interagency agreement between these agencies under Subchapter III of the federal Individuals with Disabilities Education Act (IDEA); and

2. Meets the following additional requirements.

77.43(1) Licensure. Covered services shall be provided by personnel who are licensed, endorsed, registered, recognized, or qualified as provided in this subrule and shall be within the scope of the applicable license, endorsement, registration, recognition, or qualification.

a. Personnel providing audiological or speech-language services shall be licensed by the Iowa board of speech pathology and audiology as a speech pathologist or audiologist pursuant to 645—Chapters 299, 300 and 303 through 305.

b. Personnel providing physical therapy shall be licensed by the Iowa board of physical and occupational therapy as a physical therapist pursuant to 645—Chapters 199 through 204.

c. Personnel providing occupational therapy shall be licensed by the Iowa board of physical and occupational therapy as an occupational therapist pursuant to 645—Chapters 205 through 210.

d. Personnel providing psychological evaluations and counseling or psychotherapy services shall be:

(1) Endorsed by the Iowa board of educational examiners as a school psychologist pursuant to rule 282—15.11(272);

(2) Licensed by the Iowa board of psychology as a psychologist pursuant to 645—Chapters 239 through 243;

(3) Licensed by the Iowa board of social work as a social worker pursuant to 645—Chapters 279 through 284;

(4) Licensed by the Iowa board of medicine as a physician pursuant to 653—Chapters 9 through 11; or

(5) Registered by the Iowa nursing board as an advanced registered nurse practitioner pursuant to 655—Chapter 7.

e. Personnel providing nursing services shall be licensed by the Iowa nursing board as a registered or licensed practical nurse pursuant to 655—Chapters 3 through 6.

f. Personnel providing vision services shall be:

(1) Licensed by the Iowa nursing board as a registered or licensed practical nurse pursuant to 655—Chapters 3 through 6;

(2) Licensed by the Iowa board of medicine as a physician pursuant to 653—Chapters 9 through 11; or

(3) Licensed by the Iowa board of optometry as an optometrist pursuant to 645—Chapter 180.

g. Developmental services shall be provided by personnel who meet standards established pursuant to department of education rule 281—120.19(34CFR303).

- h.* Medical transportation shall be provided by licensed drivers.
- i.* Other services shall be provided by staff who are:
 - (1) Recognized as a special education paraprofessional pursuant to department of education rule 281—41.403(256B);
 - (2) Endorsed by the Iowa board of educational examiners as a school psychologist pursuant to rule 282—15.11(272);
 - (3) Endorsed by the Iowa board of educational examiners as a speech-language pathologist pursuant to rule 282—15.12(272);
 - (4) Endorsed by the Iowa board of educational examiners as an orientation and mobility specialist pursuant to rule 282—15.15(272);
 - (5) Endorsed by the Iowa board of educational examiners as a school occupational therapist pursuant to rule 282—15.16(272);
 - (6) Endorsed by the Iowa board of educational examiners as a school physical therapist pursuant to rule 282—15.17(272);
 - (7) Endorsed by the Iowa board of educational examiners as a special education nurse pursuant to rule 282—15.18(272);
 - (8) Endorsed by the Iowa board of educational examiners as a school social worker pursuant to rule 282—15.19(272);
 - (9) Licensed by the Iowa nursing board as a registered or licensed practical nurse pursuant to 655—Chapters 3 through 6; or
 - (10) Licensed by the Iowa board of medicine as a physician pursuant to 653—Chapters 9 through 11.

77.43(2) Documentation requirements. As a condition of participation, the provider shall be responsible for maintaining accurate and current documentation of services provided in the child's record. Documentation of all services performed is required and must include:

- a.* Date, time, location, and description of each service provided and identification of the individual rendering the service by name and professional or paraprofessional designation.
- b.* An assessment and response to interventions and services.
- c.* An individual family service plan (IFSP) including all changes and revisions, as developed by the service coordinator pursuant to rule 281—41.5(256B,34CFR300).
- d.* Documentation of progress toward achieving the child's or family's action steps and outcomes as identified in the individual family service plan (IFSP).

This rule is intended to implement Iowa Code section 249A.4.

441—77.44(249A) Local education agency services providers. School districts accredited by the department of education pursuant to 281—Chapter 12, the Iowa Braille and Sight Saving School governed by the state board of regents pursuant to Iowa Code section 262.7(4), and the State School for the Deaf governed by the state board of regents pursuant to Iowa Code section 262.7(5) are eligible to participate in the medical assistance program as providers of local education agency (LEA) services under rule 441—78.50(249A) if the following conditions are met.

77.44(1) Licensure. Covered services shall be provided by personnel who are licensed, endorsed, registered, recognized, or qualified as provided in this subrule and shall be within the scope of the applicable license, endorsement, registration, recognition, or qualification.

- a.* Personnel providing audiological or speech-language services shall be licensed by the Iowa board of speech pathology and audiology as a speech pathologist or audiologist pursuant to 645—Chapters 299, 300 and 303 through 305.
- b.* Personnel providing physical therapy shall be licensed by the Iowa board of physical and occupational therapy as a physical therapist pursuant to 645—Chapters 199 through 204.
- c.* Personnel providing occupational therapy shall be licensed by the Iowa board of physical and occupational therapy as an occupational therapist pursuant to 645—Chapters 205 through 210.
- d.* Personnel providing psychological evaluations and counseling or psychotherapy services shall be:

- (1) Endorsed by the Iowa board of educational examiners as a school psychologist pursuant to rule 282—15.11(272);
 - (2) Licensed by the Iowa board of psychology as a psychologist pursuant to 645—Chapters 239 through 243;
 - (3) Licensed by the Iowa board of social work as a social worker pursuant to 645—Chapters 279 through 284;
 - (4) Licensed by the Iowa board of medicine as a physician pursuant to 653—Chapters 9 through 11; or
 - (5) Registered by the Iowa nursing board as an advanced registered nurse practitioner pursuant to 655—Chapter 7.
- e.* Personnel providing nursing services shall be licensed by the Iowa nursing board as a registered or licensed practical nurse pursuant to 655—Chapters 3 through 6.
 - f.* Personnel providing vision services shall be:
 - (1) Licensed by the Iowa nursing board as a registered or licensed practical nurse pursuant to 655—Chapters 3 through 6;
 - (2) Licensed by the Iowa board of medicine as a physician pursuant to 653—Chapters 9 through 11; or
 - (3) Licensed by the Iowa board of optometry as an optometrist pursuant to 645—Chapter 180.
 - g.* Developmental services shall be provided by personnel who meet standards established pursuant to department of education rule 281—120.19(34CFR303).
 - h.* Medical transportation shall be provided by licensed drivers.
 - i.* Other services shall be provided by staff who are:
 - (1) Recognized as a special education paraprofessional pursuant to department of education rule 281—41.403(256B);
 - (2) Endorsed by the Iowa board of educational examiners as a school psychologist pursuant to rule 282—15.11(272);
 - (3) Endorsed by the Iowa board of educational examiners as a speech-language pathologist pursuant to rule 282—15.12(272);
 - (4) Endorsed by the Iowa board of educational examiners as an orientation and mobility specialist pursuant to rule 282—15.15(272);
 - (5) Endorsed by the Iowa board of educational examiners as a school occupational therapist pursuant to rule 282—15.16(272);
 - (6) Endorsed by the Iowa board of educational examiners as a school physical therapist pursuant to rule 282—15.17(272);
 - (7) Endorsed by the Iowa board of educational examiners as a special education nurse pursuant to rule 282—15.18(272);
 - (8) Endorsed by the Iowa board of educational examiners as a school social worker pursuant to rule 282—15.19(272);
 - (9) Licensed by the Iowa nursing board as a registered or licensed practical nurse pursuant to 655—Chapters 3 through 6; or
 - (10) Licensed by the Iowa board of medicine as a physician pursuant to 653—Chapters 9 through 11.

77.44(2) Documentation requirements. As a condition of participation, the provider shall be responsible for maintaining accurate and current documentation in the child's record. Documentation of all services performed is required and must include:

- a.* Date, time, duration, location, and description of each service delivered and identification of the individual rendering the service by name and professional or paraprofessional designation.
- b.* An assessment and response to interventions and services.
- c.* Progress toward goals in the individual education plan (IEP) or individual health plan (IHP) pursuant to 281—Chapter 41, Division VIII, or 281—subrule 41.96(1).

This rule is intended to implement Iowa Code section 249A.4.

441—77.45(249A) Indian health service 638 facilities. A health care facility owned and operated by American Indian or Alaskan native tribes or tribal organizations with funding authorized by Title I or Title III of the Indian Self-Determination and Education Assistance Act (P.L. 93-638) is eligible to participate in the medical assistance program if the following conditions are met:

77.45(1) Licensure. Services must be rendered by practitioners who meet applicable professional licensure requirements.

77.45(2) Documentation. Medical records must be maintained at the same standards as are required for the applicable licensed medical practitioner.

This rule is intended to implement Iowa Code section 249A.4.

441—77.46(249A) HCBS children's mental health waiver service providers. HCBS children's mental health waiver services shall be rendered by provider agencies that meet the general provider standards in subrule 77.46(1) and also meet the standards in subrules 77.46(2) to 77.46(5) that are specific to the waiver services provided. A provider that is approved for the same service under another HCBS Medicaid waiver shall be eligible to enroll for that service under the children's mental health waiver.

77.46(1) General provider standards. All providers of HCBS children's mental health waiver services shall meet the following standards:

a. Fiscal capacity. Providers must demonstrate the fiscal capacity to provide services on an ongoing basis.

b. Direct care staff.

(1) Direct care staff must be at least 18 years of age.

(2) Providers must complete child abuse, dependent adult abuse, and criminal background screenings pursuant to Iowa Code section 249A.29 before employment of a staff member who will provide direct care.

(3) Direct care staff may not be the spouse of the consumer or the parent or stepparent of the consumer.

c. Outcome-based standards and quality assurance.

(1) Providers shall implement the following outcome-based standards for the rights and dignity of children with serious emotional disturbance:

1. Consumers are valued.

2. Consumers are a part of community life.

3. Consumers develop meaningful goals.

4. Consumers maintain physical and mental health.

5. Consumers are safe.

6. Consumers and their families have an impact on the services received.

(2) The department's quality assurance staff shall conduct random quality assurance reviews to assess the degree to which the outcome-based standards have been implemented in service provision. Results of outcome-based quality assurance reviews shall be forwarded to the certifying or accrediting entity.

(3) A quality assurance review shall include interviews with the consumer and the consumer's parents or legal guardian, with informed consent, and interviews with designated targeted case managers.

(4) A quality assurance review may include interviews with provider staff, review of case files, review of staff training records, review of compliance with the general provider standards in this subrule, and review of other organizational policies and procedures and documentation.

(5) Corrective action shall be required if the quality assurance review demonstrates that service provision or provider policies and procedures do not reflect the outcome-based standards. Technical assistance for corrective action shall be available from the department's quality assurance staff.

d. Incident management and reporting. As a condition of participation in the medical assistance program, HCBS children's mental health waiver service providers must comply with the requirements of Iowa Code sections 232.69 and 235B.3 regarding the reporting of child abuse and dependent adult abuse and must comply with the following incident management and reporting requirements. EXCEPTION:

The conditions in this paragraph do not apply to providers of environmental modifications and adaptive devices.

(1) Definitions.

“Major incident” means an occurrence involving a consumer during service provision that:

1. Results in a physical injury to or by the consumer that requires a physician’s treatment or admission to a hospital;
2. Results in the death of any person;
3. Requires emergency mental health treatment for the consumer;
4. Requires the intervention of law enforcement;
5. Requires a report of child abuse pursuant to Iowa Code section 232.69 or a report of dependent adult abuse pursuant to Iowa Code section 235B.3;
6. Constitutes a prescription medication error or a pattern of medication errors that leads to the outcome in paragraph “1,” “2,” or “3”; or
7. Involves a consumer’s location being unknown by provider staff who are assigned protective oversight.

“Minor incident” means an occurrence involving a consumer during service provision that is not a major incident and that:

1. Results in the application of basic first aid;
2. Results in bruising;
3. Results in seizure activity;
4. Results in injury to self, to others, or to property; or
5. Constitutes a prescription medication error.

(2) Reporting procedure for minor incidents. Minor incidents may be reported in any format designated by the provider. When a minor incident occurs or a staff member becomes aware of a minor incident, the staff member involved shall submit the completed incident report to the staff member’s supervisor within 72 hours of the incident. The completed report shall be maintained in a centralized file with a notation in the consumer’s file.

(3) Notification procedure for major incidents. When a major incident occurs or a staff member becomes aware of a major incident, the staff member involved shall notify the following persons of the incident by the end of the next calendar day after the incident:

1. The staff member’s supervisor.
2. The consumer or the consumer’s legal guardian. EXCEPTION: Notification to the consumer is required only if the incident took place outside of the provider’s service provision. Notification to the guardian, if any, is always required.
3. The consumer’s case manager.

(4) Reporting procedure for major incidents. By the end of the next calendar day after a major incident, the staff member who observed or first became aware of the incident shall also report as much information as is known about the incident to the department’s bureau of long-term care either:

1. By direct data entry into the Iowa Medicaid Provider Access System, or
2. By faxing or mailing Form 470-4698, Critical Incident Report, according to the directions on the form.

(5) Information to be reported. The following information shall be reported about a major incident:

1. The name of the consumer involved.
2. The date and time the incident occurred.
3. A description of the incident.
4. The names of all provider staff and others who were present at the time of the incident or who responded after becoming aware of the incident. The confidentiality of other waiver-eligible or non-waiver-eligible consumers who were present must be maintained by the use of initials or other means.
5. The action that the provider staff took to manage the incident.
6. The resolution of or follow-up to the incident.

7. The date the report is made and the handwritten or electronic signature of the person making the report.

(6) Response to report. Submission of the initial report will generate a workflow in the Individualized Services Information System (ISIS) for follow-up by the case manager. When complete information about a major incident is not available at the time of the initial report, the provider must submit follow-up reports until the case manager is satisfied with the incident resolution and follow-up. The completed report shall be maintained in a centralized file with a notation in the consumer's file.

(7) Tracking and analysis. The provider shall track incident data and analyze trends to assess the health and safety of consumers served and determine if changes need to be made for service implementation or if staff training is needed to reduce the number or severity of incidents.

77.46(2) *Environmental modifications, adaptive devices, and therapeutic resources providers.* The following agencies may provide environmental modifications, adaptive devices, and therapeutic resources under the children's mental health waiver:

a. A community business that:

(1) Possesses all necessary licenses and permits to operate in conformity with federal, state, and local statutes and regulations, including Iowa Code chapter 490; and

(2) Submits verification of current liability and workers' compensation insurance.

b. A retail or wholesale business that otherwise participates as a provider in the Medicaid program.

c. A home and vehicle modification provider enrolled under another HCBS Medicaid waiver.

d. A provider enrolled under the HCBS home- and community-based services intellectual disability or brain injury waiver as a supported community living provider.

e. A provider enrolled under the HCBS children's mental health waiver as a family and community support services provider.

77.46(3) *Family and community support services providers.*

a. *Qualified providers.* The following agencies may provide family and community support services under the children's mental health waiver:

(1) Behavioral health intervention providers qualified under 441—77.12(249A).

(2) Community mental health centers accredited in good standing as providers of outpatient psychotherapy and counseling under 441—Chapter 24.

b. *Staff training.* The agency shall meet the following training requirements as a condition of providing family and community support services under the children's mental health waiver:

(1) Within one month of employment, staff members must receive the following training:

1. Orientation regarding the agency's mission, policies, and procedures; and

2. Orientation regarding HCBS philosophy and outcomes for rights and dignity found in 77.36(1) "c" for the children's mental health waiver.

(2) Within four months of employment, staff members must receive training regarding the following:

1. Serious emotional disturbance in children and provision of services to children with serious emotional disturbance;

2. Confidentiality;

3. Provision of medication according to agency policy and procedure;

4. Identification and reporting of child abuse;

5. Incident reporting;

6. Documentation of service provision;

7. Appropriate behavioral interventions; and

8. Professional ethics.

(3) Until a staff member receives the training identified in subparagraphs (1) and (2), the staff member shall not provide any direct service without the presence of experienced staff.

(4) Within the first year of employment, staff members must complete 24 hours of training in children's mental health issues.

(5) During each consecutive year of employment, staff members must complete 12 hours of training in children's mental health issues.

c. Support of crisis intervention plan. As a condition of providing services under the children's mental health waiver, a family and community support provider shall develop and implement policies and procedures for maintaining the integrity of the individualized crisis intervention plan as defined in 441—24.1(225C) that is developed by each consumer's interdisciplinary team. The policies and procedures shall address:

- (1) Sharing with the case manager and the interdisciplinary team information pertinent to the development of the consumer's crisis intervention plan.
- (2) Training staff before service provision, in cooperation with the consumer's parents or legal guardian, regarding the consumer's individual mental health needs and individualized supports as identified in the crisis intervention plan.
- (3) Ensuring that all staff have access to a written copy of the most current crisis intervention plan during service provision.
- (4) Ensuring that the plan contains current and accurate information by updating the case manager within 24 hours regarding any circumstance or issue that would have an impact on the consumer's mental health or change the consumer's crisis intervention plan.

d. Intake, admission, and discharge. As a condition of providing services under the children's mental health waiver, a family and community support provider shall have written policies and procedures for intake, admission, and discharge.

77.46(4) In-home family therapy providers.

a. Qualified providers. The following agencies may provide in-home family therapy under the children's mental health waiver:

- (1) Community mental health centers accredited in good standing as providers of outpatient psychotherapy and counseling under 441—Chapter 24.
- (2) Mental health professionals licensed pursuant to 645—Chapter 31, 240, or 280 or possessing an equivalent license in another state.

b. Staff training. The agency shall meet the following training requirements as a condition of providing in-home family therapy under the children's mental health waiver:

- (1) Within one month of employment, staff members must receive the following training:
 1. Orientation regarding the agency's mission, policies, and procedures; and
 2. Orientation regarding HCBS philosophy and outcomes for rights and dignity found in 77.46(1) "c" for the children's mental health waiver.
- (2) Within four months of employment, staff members must receive training regarding the following:
 1. Serious emotional disturbance in children and service provision to children with serious emotional disturbance;
 2. Confidentiality;
 3. Provision of medication according to agency policy and procedure;
 4. Identification and reporting of child abuse;
 5. Incident reporting;
 6. Documentation of service provision;
 7. Appropriate behavioral interventions; and
 8. Professional ethics.
- (3) Until a staff member receives the training identified in subparagraphs (1) and (2), the staff member shall not provide any direct service without the presence of experienced staff.
- (4) Within the first year of employment, staff members must complete 24 hours of training in children's mental health issues.
- (5) During each consecutive year of employment, staff members must complete 12 hours of training in children's mental health issues.

c. Support of crisis intervention plan. As a condition of providing services under the children's mental health waiver, an in-home family therapy provider shall develop and implement policies and procedures for maintaining the integrity of the individualized crisis intervention plan as defined in

441—24.1(225C) that is developed by each consumer's interdisciplinary team. The policies and procedures shall address:

(1) Sharing with the case manager and the interdisciplinary team information pertinent to the development of the consumer's crisis intervention plan.

(2) Training staff before service provision, in cooperation with the consumer's parents or legal guardian, regarding the consumer's individual mental health needs and individualized supports as identified in the crisis intervention plan.

(3) Ensuring that all staff have access to a written copy of the most current crisis intervention plan during service provision.

(4) Ensuring that the plan contains current and accurate information by updating the case manager within 24 hours regarding any circumstance or issue that would have an impact on the consumer's mental health or change the consumer's crisis intervention plan.

d. Intake, admission, and discharge. As a condition of providing services under the children's mental health waiver, an in-home family therapy provider shall have written policies and procedures for intake, admission, and discharge.

77.46(5) Respite care providers.

a. Qualified providers. The following agencies may provide respite services under the children's mental health waiver:

(1) Providers certified or enrolled as respite providers under another Medicaid HCBS waiver.

(2) Group living foster care facilities for children licensed in good standing by the department according to 441—Chapters 112 and 114 to 116.

(3) Camps certified in good standing by the American Camping Association.

(4) Home health agencies that are certified in good standing to participate in the Medicare program.

(5) Agencies authorized to provide similar services through a contract with the department of public health (IDPH) for local public health services. The agency must provide a current IDPH local public health services contract number.

(6) Adult day care providers that are certified in good standing by the department of inspections and appeals as being in compliance with the standards for adult day services programs at 481—Chapter 70.

(7) Assisted living programs certified in good standing by the department of inspections and appeals.

(8) Residential care facilities for persons with mental retardation licensed in good standing by the department of inspections and appeals.

(9) Nursing facilities, intermediate care facilities for the mentally retarded, and hospitals enrolled as providers in the Iowa Medicaid program.

b. Staff training. The agency shall meet the following training requirements as a condition of providing respite care under the children's mental health waiver:

(1) Within one month of employment, staff members must receive the following training:

1. Orientation regarding the agency's mission, policies, and procedures; and

2. Orientation regarding HCBS philosophy and outcomes for rights and dignity for the children's mental health waiver in 77.46(1) "c."

(2) Within four months of employment, staff members must receive training regarding the following:

1. Serious emotional disturbance in children and provision of services to children with serious emotional disturbance;

2. Confidentiality;

3. Provision of medication according to agency policy and procedure;

4. Identification and reporting of child abuse;

5. Incident reporting;

6. Documentation of service provision;

7. Appropriate behavioral interventions; and

8. Professional ethics.

(3) Until a staff member receives the training identified in subparagraphs (1) and (2), the staff member shall not provide any direct service without the oversight of supervisory staff and shall obtain feedback from the family within 24 hours of service provision.

(4) Within the first year of employment, staff members must complete 24 hours of training in children's mental health issues.

(5) During each consecutive year of employment, staff members must complete 12 hours of training in children's mental health issues.

c. Consumer-specific information. The following information must be written, current, and accessible to the respite provider during service provision:

(1) The consumer's legal and preferred name, birth date, and age, and the address and telephone number of the consumer's usual residence.

(2) The consumer's typical schedule.

(3) The consumer's preferences in activities and foods or any other special concerns.

(4) The consumer's crisis intervention plan.

d. Written notification of injury. The respite provider shall inform the parent, guardian or usual caregiver that written notification must be given to the respite provider of any recent injuries or illnesses that have occurred before respite provision.

e. Medication dispensing. Respite providers shall develop policies and procedures for the dispensing, storage, and recording of all prescription and nonprescription medications administered during respite provision. Home health agencies must follow Medicare regulations regarding medication dispensing.

f. Support of crisis intervention plan. As a condition of providing services under the children's mental health waiver, a respite provider shall develop and implement policies and procedures for maintaining the integrity of the individualized crisis intervention plan as defined in 441—24.1(225C) that is developed by each consumer's interdisciplinary team. The policies and procedures shall address:

(1) Sharing with the case manager and the interdisciplinary team information pertinent to the development of the consumer's crisis intervention plan.

(2) Training staff before service provision, in cooperation with the consumer's parents or legal guardian, regarding the consumer's individual mental health needs and individualized supports as identified in the crisis intervention plan.

(3) Ensuring that all staff have access to a written copy of the most current crisis intervention plan during service provision.

(4) Ensuring that the plan contains current and accurate information by updating the case manager within 24 hours regarding any circumstance or issue that would have an impact on the consumer's mental health or change the consumer's crisis intervention plan.

g. Service documentation. Documentation of respite care shall be made available to the consumer, parents, guardian, or usual caregiver upon request.

h. Capacity. A facility providing respite care under this subrule shall not exceed the facility's licensed capacity, and services shall be provided in a location and for a duration consistent with the facility's licensure.

i. Service provided outside home or facility. For respite care to be provided in a location other than the consumer's home or the provider's facility:

(1) The care must be approved by the parent, guardian or usual caregiver;

(2) The care must be approved by the interdisciplinary team in the consumer's service plan;

(3) The care must be consistent with the way the location is used by the general public; and

(4) Respite care in these locations shall not exceed 72 continuous hours.

This rule is intended to implement Iowa Code section 249A.4 and 2005 Iowa Acts, chapter 167, section 13, and chapter 117, section 3.

[ARC 7741B, IAB 5/6/09, effective 7/1/09; ARC 7936B, IAB 7/1/09, effective 9/1/09; ARC 9314B, IAB 12/29/10, effective 3/1/11; ARC 9487B, IAB 5/4/11, effective 7/1/11; ARC 1149C, IAB 10/30/13, effective 1/1/14]

441—77.47(249A) Health home services providers. Subject to the requirements of this rule, a designated provider may participate in the medical assistance program as a provider of health home services.

77.47(1) Qualifications. A designated provider of health home services must be a Medicaid-enrolled entity or provider that is determined through the provider enrollment process to have the systems and infrastructure in place to provide health home services.

a. Staffing. At a minimum, a qualifying provider must fill the following roles:

- (1) Designated practitioner.
- (2) Dedicated care coordinator.
- (3) Health coach.
- (4) Clinic support staff.

b. Data management. A qualifying provider shall ensure that all clinical data related to the member are maintained with the member's medical records through the use of health information technology.

c. Collaboration with case managers. Health homes providing services to members eligible pursuant to 441—subparagraph 78.53(2)“a”(1) or (2) must collaborate, at least quarterly, with targeted case managers, other case managers, or DHS service workers for each member receiving case management services. Strategies to prevent duplication of coordination efforts by the health home and case managers or service workers must be developed by the health home and documented upon request. Documentation may include but is not limited to records of joint staffing meetings where a member's medical needs, current activities, and waiver services needs are reviewed and appropriately updated.

d. Provision of integrated health home services. Health homes providing services to members eligible pursuant to 441—subparagraph 78.53(2)“a”(3) or (4) must be integrated health homes that:

- (1) Consist of a team of health care professionals trained in providing health home services to members with a serious mental illness (SMI) and to members with a serious emotional disturbance (SED);
- (2) Have a direct agreement with the Iowa Medicaid managed behavioral health organization to provide health home services for members with SMI or SED;
- (3) Coordinate all community and social support services needs for members enrolled in the health home; and
- (4) Follow a system of care model in providing health home services to members with SED, including collaboration with the child welfare, public health, juvenile justice, and education systems.

77.47(2) Report on quality measures. As a condition of participation in the medical assistance program as a provider of health home services and of receiving payment for health home services provided, a designated provider must report to the Iowa Medicaid enterprise on measures for determining the quality of such services. When appropriate and feasible, a designated provider shall use health information technology in providing the Iowa Medicaid enterprise with such information.

77.47(3) Selection. As a condition of payment for health home services provided to a Medicaid member eligible to receive such services pursuant to 441—subrule 78.53(2), a designated provider must be selected by the member as the member's health home, as reported by provider attestation.

This rule is intended to implement Iowa Code section 249A.4 and 2011 Iowa Acts, chapter 129, section 10.

[ARC 0198C, IAB 7/11/12, effective 7/1/12; ARC 0838C, IAB 7/24/13, effective 7/1/13]

441—77.48(249A) Speech-language pathologists. Speech-language pathologists who are enrolled in the Medicare program are eligible to participate in Medicaid. Speech-language pathologists who are not enrolled in the Medicare program are eligible to participate in Medicaid if they are licensed and in independent practice, as an individual or as a group.

77.48(1) Speech-language pathologists in another state are eligible to participate if they are licensed in that state and meet the Medicare criteria for enrollment.

77.48(2) Speech-language pathologists who provide services to Medicaid members who are also Medicare beneficiaries must be enrolled in the Medicare program.

This rule is intended to implement Iowa Code section 249A.4 and 2012 Iowa Acts, Senate File 2158.
[ARC 0360C, IAB 10/3/12, effective 12/1/12]

441—77.49(249A) Physician assistants. All physician assistants licensed to practice in the state of Iowa are eligible for participation in the program. Physician assistants duly licensed to practice in other states are also eligible for participation. Enrollment is for the purpose of providing professional services for Medicaid members including orders and referrals, as required under Public Law 111-148, Section 6401, otherwise known as the Patient Protection and Affordable Care Act (PPACA). Enrollment will not affect the provider's payment arrangements with facilities or supervising providers.

This rule is intended to implement Iowa Code section 249A.4.
[ARC 0580C, IAB 2/6/13, effective 4/1/13]

441—77.50(249A) Ordering and referring providers. A provider who provides services, including orders and referrals, to a Medicaid member shall be enrolled as a Medicaid provider as a condition of payment eligibility for services rendered to that Medicaid member. A provider who does not individually bill for services rendered due to, for example, payment arrangements with a facility or supervising provider, shall also be required to enroll. Enrollment will be for the purpose of ordering or referring items and providing professional services to Medicaid members and will not affect the provider's payment arrangements with such facilities or supervising providers.

This rule is intended to implement Iowa Code section 249A.4.
[ARC 0580C, IAB 2/6/13, effective 4/1/13]

441—77.51(249A) Accountable care organizations. Subject to the requirements of this rule, a designated provider may participate in the medical assistance program as an accountable care organization (ACO).

77.51(1) ACO qualifications. ACO entities must meet the following requirements for participation as an ACO:

a. An ACO must be a Medicaid-enrolled provider. An ACO must complete enrollment in accordance with rule 441—79.14(249A).

b. The ACO shall execute a provider participation agreement in accordance with rule 441—79.6(249A).

c. An ACO must complete Form 470-5264, Iowa Wellness Plan ACO Readiness Application. The department reserves the right to approve the application.

d. The department and ACO shall enter into an agreement on Form 470-5218, Iowa Medicaid Accountable Care Organization (ACO) Agreement. The ACO shall comply with all requirements as identified in Form 470-5218.

e. The department reserves the right to restrict ACO enrollment so that the mixture of enrolled ACOs best matches the needs of the Medicaid member population.

77.51(2) Member selection. Medicaid members eligible for services from providers attributed to an ACO shall be required to choose their providers in accordance with 441—subrules 88.3(2) and 88.3(7).

This rule is intended to implement Iowa Code section 249A.4.
[ARC 1698C, IAB 10/29/14, effective 1/1/15]

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CHAPTER 78
AMOUNT, DURATION AND SCOPE OF
MEDICAL AND REMEDIAL SERVICES

[Prior to 7/1/83, Social Services[770] Ch 78]

[Prior to 2/11/87, Human Services[498]]

441—78.1(249A) Physicians' services. Payment will be approved for all medically necessary services and supplies provided by the physician including services rendered in the physician's office or clinic, the home, in a hospital, nursing home or elsewhere.

Payment shall be made for all services rendered by a doctor of medicine or osteopathy within the scope of this practice and the limitations of state law subject to the following limitations and exclusions:

78.1(1) Payment will not be made for:

a. Drugs dispensed by a physician or other legally qualified practitioner (dentist, podiatrist, optometrist, physician assistant, or advanced registered nurse practitioner) unless it is established that there is no licensed retail pharmacy in the community in which the legally qualified practitioner's office is maintained. Rate of payment shall be established as in subrule 78.2(2), but no professional fee shall be paid. Payment will not be made for biological supplies and drugs provided free of charge to practitioners by the state department of public health.

b. Routine physical examinations. Rescinded IAB 8/1/07, effective 8/1/07.

c. Treatment of certain foot conditions as specified in 78.5(2) "a," "b," and "c."

d. Acupuncture treatments.

e. Rescinded 9/6/78.

f. Unproven or experimental medical and surgical procedures. The criteria in effect in the Medicare program shall be utilized in determining when a given procedure is unproven or experimental in nature.

g. Charges for surgical procedures on the "Outpatient/Same Day Surgery List" produced by the Iowa Foundation for Medical Care or associated inpatient care charges when the procedure is performed in a hospital on an inpatient basis unless the physician has secured approval from the hospital's utilization review department prior to the patient's admittance to the hospital. Approval shall be granted only when inpatient care is deemed to be medically necessary based on the condition of the patient or when the surgical procedure is not performed as a routine, primary, independent procedure. The "Outpatient/Same Day Surgery List" shall be published by the department in the provider manuals for hospitals and physicians. The "Outpatient/Same Day Surgery List" shall be developed by the Iowa Foundation for Medical Care, and shall include procedures which can safely and effectively be performed in a doctor's office or on an outpatient basis in a hospital. The Iowa Foundation for Medical Care may add, delete, or modify entries on the "Outpatient/Same Day Surgery List."

h. Elective, non-medically necessary cesarean section (C-section) deliveries.

78.1(2) Drugs and supplies may be covered when prescribed by a legally qualified practitioner as provided in this rule.

a. Drugs are covered as provided by rule 441—78.2(249A).

b. Medical supplies are payable when ordered by a legally qualified practitioner for a specific rather than incidental use, subject to the conditions specified in rule 441—78.10(249A). When a member is receiving care in a nursing facility or residential care facility, payment will be approved only for the following supplies when prescribed by a legally qualified practitioner:

(1) Colostomy and ileostomy appliances.

(2) Colostomy and ileostomy care dressings, liquid adhesive and adhesive tape.

(3) Disposable irrigation trays or sets.

(4) Disposable catheterization trays or sets.

(5) Indwelling Foley catheter.

(6) Disposable saline enemas.

(7) Diabetic supplies including needles and syringes, blood glucose test strips, and diabetic urine test supplies.

c. Prescription records are required for all drugs as specified in Iowa Code sections 124.308, 155A.27 and 155A.29. For the purposes of the medical assistance program, prescriptions for medical supplies are required and shall be subject to the same provisions.

d. Rescinded IAB 1/30/08, effective 4/1/08.

e. In order to be paid for the administration of a vaccine covered under the Vaccines for Children (VFC) Program, a physician must enroll in the VFC program. Payment for the vaccine will be approved only if the VFC program stock has been depleted.

f. Nonprescription drugs. Rescinded IAB 1/30/08, effective 4/1/08.

78.1(3) Payment will be approved for injections provided they are reasonable, necessary, and related to the diagnosis and treatment of an illness or injury. When billing for an injection, the legally qualified practitioner must specify the brand name of the drug and the manufacturer, the strength of the drug, the amount administered, and the charge of each injection. When the strength and dosage of the drug is not included, payment will be made based on the customary dosage. The following exclusions are applicable.

a. Payment will not be approved for injections when they are considered by standards of medical practice not to be specific or effective treatment for the particular condition for which they are administered.

b. Payment will not be approved for an injection when administered for a reason other than the treatment of a particular condition, illness, or injury. When injecting an amphetamine or legend vitamin, prior approval must be obtained as specified in 78.1(2)“a”(3).

c. Payment will not be approved when injection is not an indicated method of administration according to accepted standards of medical practice.

d. Allergenic extract materials provided the patient for self-administration shall not exceed a 90-day supply.

e. Payment will not be approved when an injection is determined to fall outside of what is medically reasonable or necessary based on basic standards of medical practice for the required level of care for a particular condition.

f. Payment for vaccines available through the Vaccines for Children (VFC) Program will be approved only if the VFC program stock has been depleted.

g. Payment will not be approved for injections of “covered Part D drugs” as defined by 42 U.S.C. Section 1395w-102(e)(1)-(2) for any “Part D eligible individual” as defined in 42 U.S.C. Section 1395w-101(a)(3)(A), including an individual who is not enrolled in a Part D plan.

78.1(4) For the purposes of this program, cosmetic, reconstructive, or plastic surgery is surgery which can be expected primarily to improve physical appearance or which is performed primarily for psychological purposes or which restores form but which does not correct or materially improve the bodily functions. When a surgical procedure primarily restores bodily function, whether or not there is also a concomitant improvement in physical appearance, the surgical procedure does not fall within the provisions set forth in this subrule. Surgeries for the purpose of sex reassignment are not considered as restoring bodily function and are excluded from coverage.

a. Coverage under the program is generally not available for cosmetic, reconstructive, or plastic surgery. However, under certain limited circumstances payment for otherwise covered services and supplies may be provided in connection with cosmetic, reconstructive, or plastic surgery as follows:

(1) Correction of a congenital anomaly; or

(2) Restoration of body form following an accidental injury; or

(3) Revision of disfiguring and extensive scars resulting from neoplastic surgery.

(4) Generally, coverage is limited to those cosmetic, reconstructive, or plastic surgery procedures performed no later than 12 months subsequent to the related accidental injury or surgical trauma. However, special consideration for exception will be given to cases involving children who may require a growth period.

b. Cosmetic, reconstructive, or plastic surgery performed in connection with certain conditions is specifically excluded. These conditions are:

(1) Dental congenital anomalies, such as absent tooth buds, malocclusion, and similar conditions.

(2) Procedures related to transsexualism, hermaphroditism, gender identity disorders, or body dysmorphic disorders.

(3) Cosmetic, reconstructive, or plastic surgery procedures performed primarily for psychological reasons or as a result of the aging process.

(4) Breast augmentation mammoplasty, surgical insertion of prosthetic testicles, penile implant procedures, and surgeries for the purpose of sex reassignment.

c. When it is determined that a cosmetic, reconstructive, or plastic surgery procedure does not qualify for coverage under the program, all related services and supplies, including any institutional costs, are also excluded.

d. Following is a partial list of cosmetic, reconstructive, or plastic surgery procedures which are not covered under the program. This list is for example purposes only and is not considered all inclusive.

(1) Any procedure performed for personal reasons, to improve the appearance of an obvious feature or part of the body which would be considered by an average observer to be normal and acceptable for the patient's age or ethnic or racial background.

(2) Cosmetic, reconstructive, or plastic surgical procedures which are justified primarily on the basis of a psychological or psychiatric need.

(3) Augmentation mammoplasties.

(4) Face lifts and other procedures related to the aging process.

(5) Reduction mammoplasties, unless there is medical documentation of intractable pain not amenable to other forms of treatment as the result of increasingly large pendulous breasts.

(6) Panniculectomy and body sculpture procedures.

(7) Repair of sagging eyelids, unless there is demonstrated and medically documented significant impairment of vision.

(8) Rhinoplasties, unless there is evidence of accidental injury occurring within the past six months which resulted in significant obstruction of breathing.

(9) Chemical peeling for facial wrinkles.

(10) Dermabrasion of the face.

(11) Revision of scars resulting from surgery or a disease process, except disfiguring and extensive scars resulting from neoplastic surgery.

(12) Removal of tattoos.

(13) Hair transplants.

(14) Electrolysis.

(15) Sex reassignment.

(16) Penile implant procedures.

(17) Insertion of prosthetic testicles.

e. Coverage is available for otherwise covered services and supplies required in the treatment of complications resulting from a noncovered incident or treatment, but only when the subsequent complications represent a separate medical condition such as systemic infection, cardiac arrest, acute drug reaction, or similar conditions. Coverage shall not be extended for any subsequent care or procedure related to the complication that is essentially similar to the initial noncovered care. An example of a complication similar to the initial period of care would be repair of facial scarring resulting from dermabrasion for acne.

78.1(5) The legally qualified practitioner's prescription for medical equipment, appliances, or prosthetic devices shall include the patient's diagnosis and prognosis, the reason the item is required, and an estimate in months of the duration of the need. Payment will be made in accordance with rule 78.10(249A).

78.1(6) Payment will be approved for the examination to establish the need for orthopedic shoes in accordance with rule 441—78.15(249A).

78.1(7) No payment shall be made for the services of a private duty nurse.

78.1(8) Payment for mileage shall be the same as that in effect in part B of Medicare.

78.1(9) Payment will be approved for visits to patients in nursing facilities subject to the following conditions:

a. Payment will be approved for only one visit to the same patient in a calendar month. Payment for further visits will be made only when the need for the visits is adequately documented by the physician.

b. When only one patient is seen in a single visit the allowance shall be based on a follow-up home visit. When more than one patient is seen in a single visit, payment shall be based on a follow-up office visit. In the absence of information on the claim, the carrier will assume that more than one patient was seen, and payment approved on that basis.

c. Payment will be approved for mileage in connection with nursing home visits when:

- (1) It is necessary for the physician to travel outside the home community, and
- (2) There are not physicians in the community in which the nursing home is located.

d. Payment will be approved for tasks related to a resident receiving nursing facility care which are performed by a physician's employee who is a nurse practitioner, clinical nurse specialist, or physician assistant as specified in 441—paragraph 81.13(13) "e." On-site supervision of the physician is not required for these services.

78.1(10) Payment will be approved in independent laboratory when it has been certified as eligible to participate in Medicare.

78.1(11) Rescinded, effective 8/1/87.

78.1(12) Payment will be made on the same basis as in Medicare for services associated with treatment of chronic renal disease including physician's services, hospital care, renal transplantation, and hemodialysis, whether performed on an inpatient or outpatient basis. Payment will be made for deductibles and coinsurance for those persons eligible for Medicare.

78.1(13) Payment will be made to the physician for services rendered by auxiliary personnel employed by the physician and working under the direct personal supervision of the physician, when such services are performed incident to the physician's professional service.

a. Auxiliary personnel are nurses, physician's assistants, psychologists, social workers, audiologists, occupational therapists and physical therapists.

b. An auxiliary person is considered to be an employee of the physician if the physician:

- (1) Is able to control the manner in which the work is performed, i.e., is able to control when, where and how the work is done. This control need not be actually exercised by the physician.
- (2) Sets work standards.
- (3) Establishes job description.
- (4) Withholds taxes from the wages of the auxiliary personnel.

c. Direct personal supervision in the office setting means the physician must be present in the same office suite, not necessarily the same room, and be available to provide immediate assistance and direction.

Direct personal supervision outside the office setting, such as the member's home, hospital, emergency room, or nursing facility, means the physician must be present in the same room as the auxiliary person.

Advanced registered nurse practitioners certified under board of nursing rules 655—Chapter 7 performing services within their scope of practice are exempt from the direct personal supervision requirement for the purpose of reimbursement to the employing physicians. In these exempted circumstances, the employing physicians must still provide general supervision and be available to provide immediate needed assistance by telephone. Advanced registered nurse practitioners who prescribe drugs and medical devices are subject to the guidelines in effect for physicians as specified in rule 441—78.1(249A).

A physician assistant licensed under board of physician assistants' professional licensure rules in 645—Chapter 325 is exempt from the direct personal supervision requirement but the physician must still provide general supervision and be available to provide immediate needed assistance by telephone. Physician assistants who prescribe drugs and medical devices are subject to the guidelines in effect for physicians as specified in rule 441—78.1(249A).

d. Services incident to the professional services of the physician means the service provided by the auxiliary person must be related to the physician's professional service to the member. If the physician

has not or will not perform a personal professional service to the member, the clinical records must document that the physician assigned treatment of the member to the auxiliary person.

78.1(14) Payment will be made for persons aged 20 and under for nutritional counseling provided by a licensed dietitian employed by or under contract with a physician for a nutritional problem or condition of a degree of severity that nutritional counseling beyond that normally expected as part of the standard medical management is warranted. For persons eligible for the WIC program, a WIC referral is required. Medical necessity for nutritional counseling services exceeding those available through WIC shall be documented.

78.1(15) The certification of inpatient hospital care shall be the same as that in effect in part A of Medicare. The hospital admittance record is sufficient for the original certification.

78.1(16) No payment will be made for sterilization of an individual under the age of 21 or who is mentally incompetent or institutionalized. Payment will be made for sterilization performed on an individual who is aged 21 or older at the time the informed consent is obtained and who is mentally competent and not institutionalized when all the conditions in this subrule are met.

a. The following definitions are pertinent to this subrule:

(1) Sterilization means any medical procedure, treatment, or operation performed for the purpose of rendering an individual permanently incapable of reproducing and which is not a necessary part of the treatment of an existing illness or medically indicated as an accompaniment of an operation on the genital urinary tract. Mental illness or retardation is not considered an illness or injury.

(2) Hysterectomy means a medical procedure or operation to remove the uterus.

(3) Mentally incompetent individual means a person who has been declared mentally incompetent by a federal, state or local court of jurisdiction for any purpose, unless the individual has been declared competent for purposes which include the ability to consent to sterilization.

(4) Institutionalized individual means an individual who is involuntarily confined or detained, under a civil or criminal statute, in a correctional or rehabilitative facility, including a mental hospital or other facility for the care and treatment of mental illness, or an individual who is confined under a voluntary commitment in a mental hospital or other facility for the care and treatment of mental illness.

b. The sterilization shall be performed as the result of a voluntary request for the services made by the person on whom the sterilization is performed. The person's consent for sterilization shall be documented on:

(1) Form 470-0835 or 470-0835(S), Consent Form, or

(2) An official sterilization consent form from another state's Medicaid program that contains all information found on the Iowa form and complies with all applicable federal regulations.

c. The person shall be advised prior to the receipt of consent that no benefits provided under the medical assistance program or other programs administered by the department may be withdrawn or withheld by reason of a decision not to be sterilized.

d. The person shall be informed that the consent can be withheld or withdrawn any time prior to the sterilization without prejudicing future care and without loss of other project or program benefits.

e. The person shall be given a complete explanation of the sterilization. The explanation shall include:

(1) A description of available alternative methods and the effect and impact of the proposed sterilization including the fact that it must be considered to be an irreversible procedure.

(2) A thorough description of the specific sterilization procedure to be performed and benefits expected.

(3) A description of the attendant discomforts and risks including the type and possible effects of any anesthetic to be used.

(4) An offer to answer any inquiries the person to be sterilized may have concerning the procedure to be performed. The individual shall be provided a copy of the informed consent form in addition to the oral presentation.

f. At least 30 days and not more than 180 days shall have elapsed following the signing of the informed consent except in the case of premature delivery or emergency abdominal surgery which occurs

not less than 72 hours after the informed consent was signed. The informed consent shall have been signed at least 30 days before the expected delivery date for premature deliveries.

g. The information in paragraphs “*b*” through “*f*” shall be effectively presented to a blind, deaf, or otherwise handicapped individual and an interpreter shall be provided when the individual to be sterilized does not understand the language used on the consent form or used by the person obtaining consent. The individual to be sterilized may have a witness of the individual’s choice present when consent is obtained.

h. The consent form described in paragraph 78.1(16) “*b*” shall be attached to the claim for payment and shall be signed by:

- (1) The person to be sterilized,
- (2) The interpreter, when one was necessary,
- (3) The physician, and
- (4) The person who provided the required information.

i. Informed consent shall not be obtained while the individual to be sterilized is:

- (1) In labor or childbirth, or
- (2) Seeking to obtain or obtaining an abortion, or
- (3) Under the influence of alcohol or other substance that affects the individual’s state of awareness.

j. Payment will be made for a medically necessary hysterectomy only when it is performed for a purpose other than sterilization and only when one or more of the following conditions is met:

(1) The individual or representative has signed an acknowledgment that she has been informed orally and in writing from the person authorized to perform the hysterectomy that the hysterectomy will make the individual permanently incapable of reproducing, or

(2) The individual was already sterile before the hysterectomy, the physician has certified in writing that the individual was already sterile at the time of the hysterectomy and has stated the cause of the sterility, or

(3) The hysterectomy was performed as a result of a life-threatening emergency situation in which the physician determined that prior acknowledgment was not possible and the physician includes a description of the nature of the emergency.

78.1(17) Abortions. Payment for an abortion or related service is made when Form 470-0836 is completed for the applicable circumstances and is attached to each claim for services. Payment for an abortion is made under one of the following circumstances:

a. The physician certifies that the pregnant woman’s life would be endangered if the fetus were carried to term.

b. The physician certifies that the fetus is physically deformed, mentally deficient or afflicted with a congenital illness and the physician states the medical indication for determining the fetal condition.

c. The pregnancy was the result of rape reported to a law enforcement agency or public or private health agency which may include a family physician within 45 days of the date of occurrence of the incident. The report shall include the name, address, and signature of the person making the report. Form 470-0836 shall be signed by the person receiving the report of the rape.

d. The pregnancy was the result of incest reported to a law enforcement agency or public or private health agency including a family physician no later than 150 days after the date of occurrence. The report shall include the name, address, and signature of the person making the report. Form 470-0836 shall be signed by the person receiving the report of incest.

78.1(18) Payment and procedure for obtaining eyeglasses, contact lenses, and visual aids, shall be the same as described in 441—78.6(249A). (Cross-reference 78.28(3))

78.1(19) Preprocedure review by the Iowa Foundation for Medical Care (IFMC) will be required if payment under Medicaid is to be made for certain frequently performed surgical procedures which have a wide variation in the relative frequency the procedures are performed. Preprocedure surgical review applies to surgeries performed in hospitals (outpatient and inpatient) and ambulatory surgical centers. Approval by the IFMC will be granted only if the procedures are determined to be necessary based on the condition of the patient and the published criteria established by the IFMC and the department. If not so approved by the IFMC, payment will not be made under the program to the physician or to the facility

in which the surgery is performed. The criteria are available from IFMC, 6000 Westown Parkway, Suite 350E, West Des Moines, Iowa 50265-7771, or in local hospital utilization review offices.

The “Preprocedure Surgical Review List” shall be published by the department in the provider manuals for physicians, hospitals, and ambulatory surgical centers. The “Preprocedure Surgical Review List” shall be developed by the department with advice and consultation from the IFMC and appropriate professional organizations and will list the procedures for which prior review is required and the steps that must be followed in requesting such review. The department shall update the “Preprocedure Surgical Review List” annually. (Cross-reference 78.28(1) “e.”)

78.1(20) Transplants.

a. Payment will be made only for the following organ and tissue transplant services:

(1) Kidney, cornea, skin, and bone transplants.

(2) Allogeneic stem cell transplants for the treatment of aplastic anemia, severe combined immunodeficiency disease (SCID), Wiskott-Aldrich syndrome, follicular lymphoma, Fanconi anemia, paroxysmal nocturnal hemoglobinuria, pure red cell aplasia, amegakaryocytosis/congenital thrombocytopenia, beta thalassemia major, sickle cell disease, Hurler’s syndrome (mucopolysaccharidosis type 1 [MPS-1]), adrenoleukodystrophy, metachromatic leukodystrophy, refractory anemia, agnogenic myeloid metaplasia (myelofibrosis), familial erythrophagocytic lymphohistiocytosis and other histiocytic disorders, acute myelofibrosis, Diamond-Blackfan anemia, epidermolysis bullosa, or the following types of leukemia: acute myelocytic leukemia, chronic myelogenous leukemia, juvenile myelomonocytic leukemia, chronic myelomonocytic leukemia, acute myelogenous leukemia, and acute lymphocytic leukemia.

(3) Autologous stem cell transplants for treatment of the following conditions: acute leukemia; chronic lymphocytic leukemia; plasma cell leukemia; non-Hodgkin’s lymphomas; Hodgkin’s lymphoma; relapsed Hodgkin’s lymphoma; lymphomas presenting poor prognostic features; follicular lymphoma; neuroblastoma; medulloblastoma; advanced Hodgkin’s disease; primitive neuroendocrine tumor (PNET); atypical/rhabdoid tumor (ATRT); Wilms’ tumor; Ewing’s sarcoma; metastatic germ cell tumor; or multiple myeloma.

(4) Liver transplants for persons with extrahepatic biliary artesia or any other form of end-stage liver disease, except that coverage is not provided for persons with a malignancy extending beyond the margins of the liver.

Liver transplants require preprocedure review by the Iowa Foundation for Medical Care. (Cross-reference 78.1(19) and 78.28(1) “f.”)

Covered liver transplants are payable only when performed in a facility that meets the requirements of 78.3(10).

(5) Heart transplants for persons with inoperable congenital heart defects, heart failure, or related conditions. Artificial hearts and ventricular assist devices as a temporary life-support system until a human heart becomes available for transplants are covered. Artificial hearts and ventricular assist devices as a permanent replacement for a human heart are not covered. Heart-lung transplants are covered where bilateral or unilateral lung transplantation with repair of a congenital cardiac defect is contraindicated.

Heart transplants, heart-lung transplants, artificial hearts, and ventricular assist devices described above require preprocedure review by the Iowa Medicaid enterprise medical services prior authorization unit. (Cross-reference 78.1(19) and 78.28(1) “f.”) Covered heart transplants are payable only when performed in a facility that meets the requirements of 78.3(10).

(6) Lung transplants. Lung transplants for persons having end-stage pulmonary disease. Lung transplants require preprocedure review by the Iowa Foundation for Medical Care. (Cross-reference 78.1(19) and 78.28(1) “f.”) Covered transplants are payable only when performed in a facility that meets the requirements of 78.3(10). Heart-lung transplants are covered consistent with criteria in subparagraph (5) above.

(7) Pancreas transplants for persons with type I diabetes mellitus, as follows:

1. Simultaneous pancreas-kidney transplants and pancreas after kidney transplants are covered.
2. Pancreas transplants alone are covered for persons exhibiting any of the following:

- A history of frequent, acute, and severe metabolic complications (e.g., hypoglycemia, hyperglycemia, or ketoacidosis) requiring medical attention.

- Clinical problems with exogenous insulin therapy that are so severe as to be incapacitating.
- Consistent failure of insulin-based management to prevent acute complications.

The pancreas transplants listed under this subparagraph require preprocedure review by the Iowa Foundation for Medical Care. (Cross-reference 78.1(19) and 78.28(1)“f.”)

Covered transplants are payable only when performed in a facility that meets the requirements of 78.3(10).

Transplantation of islet cells or partial pancreatic tissue is not covered.

b. Donor expenses incurred directly in connection with a covered transplant are payable. Expenses incurred for complications that arise with respect to the donor are covered only if they are directly and immediately attributed to surgery. Expenses of searching for a donor are not covered.

c. All transplants must be medically necessary and meet other general requirements of this chapter for physician and hospital services.

d. Payment will not be made for any transplant not specifically listed in paragraph “a.”

78.1(21) Utilization review. Utilization review shall be conducted of Medicaid members who access more than 24 outpatient visits in any 12-month period from physicians, advanced registered nurse practitioners, federally qualified health centers, other clinics, and emergency rooms. For the purposes of utilization review, the term “physician” does not include a psychiatrist. Refer to rule 441—76.9(249A) for further information concerning the member lock-in program.

78.1(22) Risk assessment. Risk assessment, using Form 470-2942, Medicaid Prenatal Risk Assessment, shall be completed at the initial visit during a Medicaid member’s pregnancy.

a. If the risk assessment reflects a low-risk pregnancy, the assessment shall be completed again at approximately the twenty-eighth week of pregnancy.

b. If the risk assessment reflects a high-risk pregnancy, referral shall be made for enhanced services. Enhanced services include health education, social services, nutrition education, and a postpartum home visit. Additional reimbursement shall be provided for obstetrical services related to a high-risk pregnancy. (See description of enhanced services at subrule 78.25(3).)

78.1(23) EPSDT care coordination. Rescinded IAB 12/3/08, effective 2/1/09.

78.1(24) Topical fluoride varnish. Payment shall be made for application of an FDA-approved topical fluoride varnish, as defined by the Current Dental Terminology, Third Edition (CDT-3), for the purpose of preventing the worsening of early childhood caries in children aged 0 to 36 months of age, when rendered by physicians acting within the scope of their practice, licensure, and other applicable state law, subject to the following provisions and limitations:

a. Application of topical fluoride varnish must be provided in conjunction with an early and periodic screening, diagnosis, and treatment (EPSDT) examination which includes a limited oral screening.

b. Separate payment shall be available only for application of topical fluoride varnish, which shall be at the same rate of reimbursement paid to dentists for providing this service. Separate payment for the limited oral screening shall not be available, as this service is already part of and paid under the EPSDT screening examination.

c. Parents, legal guardians, or other authorized caregivers of children receiving application of topical fluoride varnish as part of an EPSDT screening examination shall be informed by the physician or auxiliary staff employed by and under the physician’s supervision that this application is not a substitute for comprehensive dental care.

d. Physicians rendering the services under this subrule shall make every reasonable effort to refer or facilitate referral of these children for comprehensive dental care rendered by a dental professional.

This rule is intended to implement Iowa Code section 249A.4.

[ARC 8714B, IAB 5/5/10, effective 5/1/10; ARC 0065C, IAB 4/4/12, effective 6/1/12; ARC 0305C, IAB 9/5/12, effective 11/1/12; ARC 0846C, IAB 7/24/13, effective 7/1/13; ARC 1052C, IAB 10/2/13, effective 11/6/13; ARC 1297C, IAB 2/5/14, effective 4/1/14]

441—78.2(249A) Prescribed outpatient drugs. Payment will be made for “covered outpatient drugs” as defined in 42 U.S.C. Section 1396r-8(k)(2)-(4) subject to the conditions and limitations specified in this rule.

78.2(1) *Qualified prescriber.* All drugs are covered only if prescribed by a legally qualified practitioner (physician, dentist, podiatrist, optometrist, physician assistant, or advanced registered nurse practitioner). Pursuant to Public Law 111-148, Section 6401, any practitioner prescribing drugs must be enrolled with the Iowa Medicaid enterprise in order for such prescribed drugs to be eligible for payment.

78.2(2) *Prescription required.* As a condition of payment for all drugs, including “nonprescription” or “over-the-counter” drugs that may otherwise be dispensed without a prescription, a prescription shall be transmitted as specified in Iowa Code sections 124.308 and 155A.27, subject to the provisions of Iowa Code section 155A.29 regarding refills. All prescriptions shall be available for audit by the department.

78.2(3) *Qualified source.* All drugs are covered only if marketed by manufacturers that have signed a Medicaid rebate agreement with the Secretary of Health and Human Services in accordance with Public Law 101-508 (Omnibus Budget Reconciliation Act of 1990).

78.2(4) *Prescription drugs.* Drugs that may be dispensed only upon a prescription are covered subject to the following limitations.

a. Prior authorization is required as specified in the preferred drug list published by the department pursuant to Iowa Code section 249A.20A as amended by 2010 Iowa Acts, Senate File 2088, section 347.

(1) For any drug requiring prior authorization, reimbursement will be made for a 72-hour or three-day supply dispensed in an emergency when a prior authorization request cannot be submitted.

(2) Unless the manufacturer or labeler of a mental health prescription drug that has a significant variation in therapeutic or side effect profile from other drugs in the same therapeutic class enters into a contract to provide the state with a supplemental rebate, the drug may be placed on the preferred drug list as nonpreferred, with prior authorization required. However, prior authorization shall not be required for such a drug for a member whose regimen on the drug was established before January 1, 2011, as verified by documented pharmacy claims.

(3) For mental health prescription drugs requiring prior authorization that have a significant variation in therapeutic or side effect profile from other drugs in the same therapeutic class, reimbursement will be made for up to a seven-day supply pending prior authorization. A request for prior authorization shall be deemed approved if the prescriber:

1. Has on file with the department current contact information, including a current fax number, and a signed Form 470-4914, Fax Confidentiality Certificate, and
2. Does not receive a notice of approval or disapproval within 48 hours of a request for prior authorization.

b. Payment is not made for:

(1) Drugs whose prescribed use is not for a medically accepted indication as defined by Section 1927(k)(6) of the Social Security Act.

(2) Drugs used for anorexia, weight gain, or weight loss.

(3) Drugs used for cosmetic purposes or hair growth.

(4) Rescinded IAB 2/8/12, effective 3/14/12.

(5) Otherwise covered outpatient drugs if the manufacturer seeks to require as a condition of sale that associated tests or monitoring services be purchased exclusively from the manufacturer or the manufacturer’s designee.

(6) Drugs described in Section 107(c)(3) of the Drug Amendments of 1962 and identical, similar, or related drugs (within the meaning of Section 310.6(b)(1) of Title 21 of the Code of Federal Regulations (drugs identified through the Drug Efficacy Study Implementation (DESI) review)).

(7) “Covered Part D drugs” as defined by 42 U.S.C. Section 1395w-102(e)(1)-(2) for any “Part D eligible individual” as defined by 42 U.S.C. Section 1395w-101(a)(3)(A), including a member who is not enrolled in a Medicare Part D plan.

(8) Drugs prescribed for fertility purposes, except when prescribed for a medically accepted indication other than infertility, as defined in subparagraph (1).

(9) Drugs used for the treatment of sexual or erectile dysfunction, except when used to treat a condition other than sexual or erectile dysfunction for which the drug has been approved by the U.S. Food and Drug Administration.

(10) Prescription drugs for which the prescription was executed in written (and nonelectronic) form unless the prescription was executed on a tamper-resistant pad, as required by Section 1903(i)(23) of the Social Security Act (42 U.S.C. Section 1396b(i)(23)).

(11) Drugs used for symptomatic relief of cough and colds, except for nonprescription drugs listed at subrule 78.2(5).

78.2(5) *Nonprescription drugs.* The following drugs that may otherwise be dispensed without a prescription are covered subject to the prior authorization requirements stated below and as specified in the preferred drug list published by the department pursuant to Iowa Code section 249A.20A:

- Acetaminophen tablets 325 mg, 500 mg
- Acetaminophen elixir 160 mg/5 ml
- Acetaminophen solution 100 mg/ml
- Acetaminophen suppositories 120 mg
- Artificial tears ophthalmic solution
- Artificial tears ophthalmic ointment
- Aspirin tablets 325 mg, 650 mg, 81 mg (chewable)
- Aspirin tablets, enteric coated 325 mg, 650 mg, 81 mg
- Aspirin tablets, buffered 325 mg
- Bacitracin ointment 500 units/gm
- Benzoyl peroxide 5%, gel, lotion
- Benzoyl peroxide 10%, gel, lotion
- Calcium carbonate chewable tablets 500 mg, 750 mg, 1000 mg, 1250 mg
- Calcium carbonate suspension 1250 mg/5 ml
- Calcium carbonate tablets 600 mg
- Calcium carbonate-vitamin D tablets 500 mg-200 units
- Calcium carbonate-vitamin D tablets 600 mg-200 units
- Calcium citrate tablets 950 mg (200 mg elemental calcium)
- Calcium gluconate tablets 650 mg
- Calcium lactate tablets 650 mg
- Cetirizine hydrochloride liquid 1 mg/ml
- Cetirizine hydrochloride tablets 5 mg
- Cetirizine hydrochloride tablets 10 mg
- Chlorpheniramine maleate tablets 4 mg
- Clotrimazole vaginal cream 1%
- Diphenhydramine hydrochloride capsules 25 mg
- Diphenhydramine hydrochloride elixir, liquid, and syrup 12.5 mg/5 ml
- Epinephrine racemic solution 2.25%
- Ferrous sulfate tablets 325 mg
- Ferrous sulfate elixir 220 mg/5 ml
- Ferrous sulfate drops 75 mg/0.6 ml
- Ferrous gluconate tablets 325 mg
- Ferrous fumarate tablets 325 mg
- Guaifenesin 100 mg/5 ml with dextromethorphan 10 mg/5 ml liquid
- Ibuprofen suspension 100 mg/5 ml
- Ibuprofen tablets 200 mg
- Insulin
- Lactic acid (ammonium lactate) lotion 12%
- Loperamide hydrochloride liquid 1 mg/5 ml
- Loperamide hydrochloride tablets 2 mg
- Loratadine syrup 5 mg/5 ml

Loratadine tablets 10 mg
 Magnesium hydroxide suspension 400 mg/5 ml
 Magnesium oxide capsule 140 mg (85 mg elemental magnesium)
 Magnesium oxide tablets 400 mg
 Meclizine hydrochloride tablets 12.5 mg, 25 mg oral and chewable
 Miconazole nitrate cream 2% topical and vaginal
 Miconazole nitrate vaginal suppositories, 100 mg
 Multiple vitamin and mineral products with prior authorization
 Neomycin-bacitracin-polymyxin ointment
 Niacin (nicotinic acid) tablets 50 mg, 100 mg, 250 mg, 500 mg
 Nicotine gum 2 mg, 4 mg
 Nicotine lozenge 2 mg, 4 mg
 Nicotine patch 7 mg/day, 14 mg/day and 21 mg/day
 Pediatric oral electrolyte solutions
 Permethrin lotion 1%
 Polyethylene glycol 3350 powder
 Pseudoephedrine hydrochloride tablets 30 mg, 60 mg
 Pseudoephedrine hydrochloride liquid 30 mg/5 ml
 Pyrethrins-piperonyl butoxide liquid 0.33-4%
 Pyrethrins-piperonyl butoxide shampoo 0.3-3%
 Pyrethrins-piperonyl butoxide shampoo 0.33-4%
 Salicylic acid liquid 17%
 Senna tablets 187 mg
 Sennosides-docusate sodium tablets 8.6 mg-50 mg
 Sennosides syrup 8.8 mg/5 ml
 Sennosides tablets 8.6 mg
 Sodium bicarbonate tablets 325 mg
 Sodium bicarbonate tablets 650 mg
 Sodium chloride hypertonic ophthalmic ointment 5%
 Sodium chloride hypertonic ophthalmic solution 5%
 Tolnaftate 1% cream, solution, powder
 Other nonprescription drugs listed as preferred in the preferred drug list published by the department pursuant to Iowa Code section 249A.20A.

78.2(6) *Quantity prescribed and dispensed.*

a. When it is not therapeutically contraindicated, the legally qualified practitioner shall prescribe a quantity of prescription medication sufficient for up to a 31-day supply. Oral contraceptives may be prescribed in 90-day quantities.

b. Oral solid forms of covered nonprescription items shall be prescribed and dispensed in a minimum quantity of 100 units per prescription or the currently available consumer package size except when dispensed via a unit-dose system.

78.2(7) *Lowest cost item.* The pharmacist shall dispense the lowest cost item in stock that meets the requirements of the practitioner as shown on the prescription.

78.2(8) *Consultation.* In accordance with Public Law 101-508 (Omnibus Budget Reconciliation Act of 1990), a pharmacist shall offer to discuss information regarding the use of the medication with each Medicaid member or the caregiver of a member presenting a prescription. The consultation is not required if the person refuses the consultation. Standards for the content of the consultation shall be found in rules of the Iowa board of pharmacy.

This rule is intended to implement Iowa Code section 249A.4.

[ARC 8097B, IAB 9/9/09, effective 11/1/09; ARC 9175B, IAB 11/3/10, effective 1/1/11; ARC 9699B, IAB 9/7/11, effective 9/1/11; ARC 9834B, IAB 11/2/11, effective 11/1/11; ARC 9882B, IAB 11/30/11, effective 1/4/12; ARC 9981B, IAB 2/8/12, effective 3/14/12; ARC 0305C, IAB 9/5/12, effective 11/1/12; ARC 0580C, IAB 2/6/13, effective 4/1/13]

441—78.3(249A) Inpatient hospital services. Payment for inpatient hospital admission is approved when it meets the criteria for inpatient hospital care as determined by the Iowa Medicaid enterprise. All cases are subject to random retrospective review and may be subject to a more intensive retrospective review if abuse is suspected. In addition, transfers, outliers, and readmissions within 31 days are subject to random review. Selected admissions and procedures are subject to a 100 percent review before the services are rendered. Medicaid payment for inpatient hospital admissions and continued stays are approved when the admissions and continued stays are determined to meet the criteria for inpatient hospital care. (Cross-reference 78.28(5)) The criteria are available from the IME Medical Services Unit, 100 Army Post Road, Des Moines, Iowa 50315, or in local hospital utilization review offices. No payment will be made for waiver days.

See rule 441—78.31(249A) for policies regarding payment of hospital outpatient services.

If the recipient is eligible for inpatient or outpatient hospital care through the Medicare program, payment will be made for deductibles and coinsurance as set out in 441—subrule 79.1(22).

The DRG payment calculations include any special services required by the hospital, including a private room.

78.3(1) Payment for Medicaid-certified physical rehabilitation units will be approved for the day of admission but not the day of discharge or death.

78.3(2) No payment will be approved for private duty nursing.

78.3(3) Certification of inpatient hospital care shall be the same as that in effect in part A of Medicare. The hospital admittance records are sufficient for the original certification.

78.3(4) Services provided for intestinal or gastric bypass surgery for treatment of obesity requires prior approval, which must be obtained by the attending physician before surgery is performed.

78.3(5) Payment will be approved for drugs provided inpatients subject to the same provisions specified in 78.2(1) and 78.2(4) “b”(1) to (10) except for 78.2(4) “b”(7). The basis of payment for drugs administered to inpatients is through the DRG reimbursement.

a. Payment will be approved for drugs and supplies provided outpatients subject to the same provisions specified in 78.2(1) through 78.2(4) except for 78.2(4) “b”(7). The basis of payment for drugs provided outpatients is through a combination of Medicaid-determined fee schedules and ambulatory payment classification, pursuant to 441—subrule 79.1(16).

b. In order to be paid for the administration of a vaccine covered under the Vaccines for Children (VFC) Program, a hospital must enroll in the VFC program. Payment for the vaccine will be approved only if the VFC program stock has been depleted.

78.3(6) Payment for nursing care provided by a hospital shall be made to those hospitals which have been certified by the department of inspections and appeals as meeting the standards for a nursing facility.

78.3(7) Payment for inpatient hospital tests for purposes of diagnosis and treatment shall be made only when the tests are specifically ordered for the diagnosis and treatment of a particular patient’s condition by the attending physician or other licensed practitioner acting within the scope of practice as defined by law, who is responsible for that patient’s diagnosis or treatment.

78.3(8) Rescinded IAB 2/6/91, effective 4/1/91.

78.3(9) Payment will be made for sterilizations in accordance with 78.1(16).

78.3(10) Payment will be approved for organ and tissue transplant services, as specified in subrule 78.1(20). Kidney, cornea, skin, bone, allogeneic bone marrow, autologous bone marrow, heart, liver, and lung transplants are covered as specified in subrule 78.1(20). Lung transplants are payable at Medicare-designated lung transplant centers only. Heart and liver transplants are payable when performed at facilities that meet the following criteria:

a. Recipient selection and education.

(1) *Selection.* The transplant center must have written criteria based on medical need for transplantation for final facility selection of recipients. These criteria should include an equitable, consistent and practical protocol for selection of recipients. The criteria must be at least as strict as those specified by Medicare.

(2) *Education.* The transplant center will provide a written plan for recipient education. It shall include educational plans for recipient, family and significant others during all phases of the program. These phases shall include:

Intake.

Preparation and waiting period.

Preadmission.

Hospitalization.

Discharge planning.

Follow-up.

b. Staffing and resource commitment.

(1) *Transplant surgeon.* The transplant center must have on staff a qualified transplant surgeon.

The surgeon must have received at least one year of training at a transplant center approved by the American Society of Transplant Surgeons under the direction of an experienced transplant surgeon and must have had at least two years of experience in all facets of transplant surgery specific to the surgeon's specialty. This experience must include management of recipients' presurgical and postsurgical care and actual experience as a member of a transplant team at the institution. The transplant surgeon will have an understanding of the principles of and demonstrated expertise in the use of immunosuppressive therapy.

The transplant surgeon will be certified by the American Board of Thoracic Surgery or equivalent for heart transplants and the American Board of Surgery or equivalent for liver transplants.

The transplant surgeon will be the defined leader of a stable, established transplant team that has a strong commitment to the transplant program.

(2) *Transplant team.* The transplant team will be clearly defined with leadership and corresponding responsibilities of all team members identified.

The team should consist of:

A surgeon director.

A board-certified internist or pediatrician with training and expertise in organ transplantation medicine and clinical use of immunosuppressive regimens.

The transplant center will assume responsibility for initial training and continuing education of the transplant team and ancillary personnel. The center will maintain records that demonstrate competency in achieving, maintaining and improving skills in the distinct areas of expertise of each of the team members.

(3) *Physicians.* The transplant center will have on staff or available for consultation physicians with the following areas of expertise:

Anesthesiology.

Cardiology.

Dialysis.

Gastroenterology.

Hepatology.

Immunology.

Infectious diseases.

Nephrology.

Neurology.

Pathology.

Pediatrics.

Psychiatry.

Pulmonary medicine.

Radiology.

Rehabilitation medicine.

Liaison with the recipient's permanent physician is established for the purpose of providing continuity and management of the recipient's long-term care.

(4) *Support personnel and resources.* The center must have a commitment of sufficient resources and planning for implementation and operation of the transplant program. Indicators of the commitment will include the following:

Persons with expertise in the following areas available at the transplant center:

Anesthesiology.

Blood bank services.

Cardiology.

Cardiovascular surgery.

Dialysis.

Dietary services.

Gastroenterology.

Infection control.

Laboratory services (pathology, microbiology, immunology, tissue typing, and monitoring of immunosuppressive drugs).

Legal counsel familiar with transplantation laws and regulations.

Nursing service department with staff available who have expertise in the care of transplant recipients, especially in managing immunosuppressed patients and hemodynamic support.

Respiratory therapy.

Pharmaceutical services.

Physical therapy.

Psychiatry.

Psycho-social.

The center will have active cardiovascular, medical, and surgical programs with the ability and willingness to perform diagnostic and evaluative procedures appropriate to transplants on an emergency and ongoing basis.

The center will have designated an adequate number of intensive care and general service beds to support the transplant center.

(5) *Laboratory.* Each transplant center must have direct local 24-hour per day access to histocompatibility testing facilities. These facilities must meet the Standards for Histocompatibility Testing set forth by the Committee on Quality Assurance and Standards of the American Society for Histocompatibility and Immunogenetics (ASHI). As specified by ASHI, the director of the facility shall hold a doctoral degree in biological science, or be a physician, and subsequent to graduation shall have had four years' experience in immunology, two of which were devoted to formal training in human histocompatibility testing, documented to be professionally competent by external measures such as national proficiency testing, participation in national or international workshops or publications in peer-reviewed journals. The laboratory must successfully participate in a regional or national testing program.

c. Experience and survival rates.

(1) *Experience.* Centers will be given a minimum volume requirement of 12 heart or 12 liver transplants that should be met within one year. Due to special considerations such as patient case mix or donor availability, an additional one year conditional approval may be given if the minimum volume is not met the first year.

For approval of an extrarenal organ transplant program it is highly desirable that the institution: 1. has available a complete team of surgeons, physicians, and other specialists with specific experience in transplantation of that organ, or 2. has an established approved renal transplant program at that institution and personnel with expertise in the extrarenal organ system itself.

(2) *Survival rates.* The transplant center will achieve a record of acceptable performance consistent with the performance and outcomes at other successful designated transplant centers. The center will collect and maintain recipient and graft survival and complication rates. A level of satisfactory success and safety will be demonstrated with bases for substantial probability of continued performance at an acceptable level.

To encourage a high level of performance, transplant programs must achieve and maintain a minimum one-year patient survival rate of 70 percent for heart transplants and 50 percent for liver transplants.

d. Organ procurement. The transplant center will participate in a nationwide organ procurement and typing network.

Detailed plans must exist for organ procurement yielding viable transplantable organs in reasonable numbers, meeting established legal and ethical criteria.

The transplant center must be a member of the National Organ Procurement and Transplant Network.

e. Maintenance of data, research, review and evaluation.

(1) *Maintenance of data.* The transplant center will collect and maintain data on the following:

Risk and benefit.

Morbidity and mortality.

Long-term survival.

Quality of life.

Recipient demographic information.

These data should be maintained in the computer at the transplant center monthly.

The transplant center will submit the above data to the United Network of Organ Sharing yearly.

(2) *Research.* The transplant center will have a plan for and a commitment to research.

Ongoing research regarding the transplanted organs is required.

The transplant center will have a program in graduate medical education or have a formal agreement with a teaching institution for affiliation with a graduate medical education program.

(3) *Review and evaluation.* The transplant center will have a plan for ongoing evaluation of the transplantation program.

The transplant center will have a detailed plan for review and evaluation of recipient selection, preoperative, operative, postoperative and long-term management of the recipient.

The transplant center will conduct concurrent ongoing studies to ensure high quality services are provided in the transplantation program.

The transplant center will provide information to members of the transplant team and ancillary staff regarding the findings of the quality assurance studies. This information will be utilized to provide education geared toward interventions to improve staff performance and reduce complications occurring in the transplant process.

The transplant center will maintain records of all quality assurance and peer review activities concerning the transplantation program to document identification of problems or potential problems, intervention, education and follow-up.

f. Application procedure. A Medicare-designated heart, liver, or lung transplant facility needs only to submit evidence of this designation to the Iowa Medicaid enterprise provider services unit. The application procedure for other heart and liver facilities is as follows:

(1) An original and two copies of the application must be submitted on 8½ by 11 inch paper, signed by a person authorized to do so. The facility must be a participating hospital under Medicaid and must specify its provider number, and the name and telephone number of a contact person should there be questions regarding the application.

(2) Information and data must be clearly stated, well organized and appropriately indexed to aid in its review against the criteria specified in this rule. Each page must be numbered.

(3) To the extent possible, the application should be organized into five sections corresponding to each of the five major criteria and addressing, in order, each of the subcriteria identified.

(4) The application should be mailed to the Iowa Medicaid enterprise provider services unit.

g. Review and approval of facilities. An organized review committee will be established to evaluate performance and survival statistics and make recommendations regarding approval as a designated transplant center based on acceptable performance standards established by the review organization and approved by the Medicaid agency.

There will be established protocol for the systematic evaluation of patient outcome including survival statistics.

Once a facility applies for approval and is approved as a heart or liver transplant facility for Medicaid purposes, it is obliged to report immediately to the department any events or changes which would affect its approved status. Specifically, a facility must report any significant decrease in its experience level or survival rates, the transplantation of patients who do not meet its patient selection criteria, the loss of key members of the transplant team, or any other major changes that could affect the performance of heart or liver transplants at the facility. Changes from the terms of approval may lead to withdrawal of approval for Medicaid coverage of heart or liver transplants performed at the facility.

78.3(11) Payment will be approved for inpatient hospital care rendered a patient in connection with dental treatment only when the mental, physical, or emotional condition of the patient prevents the dentist from providing this necessary care in the office.

78.3(12) Payment will be approved for an assessment fee as specified in 441—paragraphs 79.1(16) “a” and “r” to determine if a medical emergency exists.

Medical emergency is defined as a sudden or unforeseen occurrence or combination of circumstances presenting a substantial risk to an individual’s health unless immediate medical treatment is given.

The determination of whether a medical emergency exists will be based on the patient’s medical condition including presenting symptoms and medical history prior to treatment or evaluation.

78.3(13) Payment for patients in acute hospital beds who are determined by IFMC to require the skilled nursing care level of care shall be made at an amount equal to the sum of the direct care rate component limit for Medicare-certified hospital-based nursing facilities pursuant to 441—subparagraph 81.6(16) “f”(3) plus the non-direct care rate component limit for Medicare-certified hospital-based nursing facilities pursuant to 441—subparagraph 81.6(16) “f”(3), with the rate component limits being revised July 1, 2001, and every second year thereafter. This rate is effective (a) as of the date of notice by IFMC that the lower level of care is required or (b) for the days IFMC determines in an outlier review that the lower level of care was required.

78.3(14) Payment for patients in acute hospital beds who are determined by IFMC to require nursing facility level of care shall be made at an amount equal to the sum of the direct care rate component limit for Medicaid nursing facilities pursuant to 441—subparagraph 81.6(16) “f”(1) plus the non-direct care rate component limit for Medicaid nursing facilities pursuant to 441—subparagraph 81.6(16) “f”(1), with the rate component limits being revised July 1, 2001, and every second year thereafter. This rate is effective (a) as of the date of notice by IFMC that the lower level of care is required or (b) for the days IFMC determines in an outlier review that the lower level of care was required.

78.3(15) Payment for inpatient hospital charges associated with surgical procedures on the “Outpatient/Same Day Surgery List” produced by the Iowa Foundation for Medical Care shall be made only when attending physician has secured approval from the hospital’s utilization review department prior to admittance to the hospital. Approval shall be granted when inpatient care is deemed to be medically necessary based on the condition of the patient or when the surgical procedure is not performed as a routine, primary, independent procedure. The “Outpatient/Same Day Surgery List” shall be published by the department in the provider manuals for hospitals and physicians. The “Outpatient/Same Day Surgery List” shall be developed by the Iowa Foundation for Medical Care, and shall include procedures which can safely and effectively be performed in a doctor’s office or on an outpatient basis in a hospital. The Iowa Foundation for Medical Care may add, delete or modify entries on the “Outpatient/Same Day Surgery List.”

78.3(16) Skilled nursing care in “swing beds.”

a. Payment will be made for medically necessary skilled nursing care when provided by a hospital participating in the swing-bed program certified by the department of inspections and appeals and approved by the U.S. Department of Health and Human Services. Payment shall be at an amount equal to the sum of the direct care rate component limit for Medicare-certified hospital-based nursing facilities pursuant to 441—subparagraph 81.6(16) “f”(3) and the non-direct care rate component limit for Medicare-certified hospital-based nursing facilities pursuant to 441—subparagraph 81.6(16) “f”(3), with the rate component limits being revised July 1, 2001, and every second year thereafter. Swing-bed placement is only intended to be short-term in nature.

b. Any payment for skilled nursing care provided in a hospital with a certified swing-bed program, for either initial admission or continued stay, will require prior authorization, subject to the following requirements:

(1) The hospital has fewer than 100 beds, excluding beds for newborns and intensive care.

(2) The hospital has an existing certification for a swing-bed program, pursuant to paragraph 78.3(16) “*a.*”

(3) The member is being admitted for nursing facility or skilled level of care (if the member has Medicare and skilled coverage has been exhausted).

(4) As part of the discharge planning process for a member requiring ongoing skilled nursing care, the hospital must:

1. Complete a level of care (LOC) determination describing a member’s LOC needs, using Form 470-5156, Swing Bed Certification.

2. Contact skilled nursing facilities within a 30-mile radius of the hospital regarding available beds to meet the member’s LOC needs.

3. Certify that no freestanding skilled nursing facility beds are available for the member within a 30-mile radius of the hospital, which will be able to appropriately meet the member’s needs and that home-based care for the member is not available or appropriate.

(5) Swing-bed stays beyond 14 days will only be approved when there is no appropriate freestanding nursing facility bed available within a 30-mile radius and home-based care for the member is not available or appropriate, as documented by the hospital seeking the swing-bed admission. For the purpose of these criteria, an “appropriate” nursing facility bed is a bed in a Medicaid-participating freestanding nursing facility that provides the LOC required for the member’s medical condition and corresponding LOC needs.

(6) A Medicaid member who has been in a swing bed beyond 14 days must be discharged to an appropriate nursing facility bed within a 30-mile radius of the swing-bed hospital or to appropriate home-based care within 72 hours of an appropriate nursing facility bed becoming available.

Preadmission screening and resident review (PASRR) rules still apply for members being transferred to a nursing facility.

78.3(17) Rescinded IAB 8/9/89, effective 10/1/89.

78.3(18) Preprocedure review by the IFMC is required if hospitals are to be reimbursed for certain frequently performed surgical procedures as set forth under subrule 78.1(19). Criteria are available from IFMC, 6000 Westown Parkway, Suite 350E, West Des Moines, Iowa 50265-7771, or in local hospital utilization review offices. (Cross-reference 78.28(5))

78.3(19) Rescinded IAB 10/8/97, effective 12/1/97.

This rule is intended to implement Iowa Code section 249A.4.

[**ARC 0065C**, IAB 4/4/12, effective 6/1/12; **ARC 0194C**, IAB 7/11/12, effective 7/1/12; **ARC 0354C**, IAB 10/3/12, effective 12/1/12; **ARC 0844C**, IAB 7/24/13, effective 7/1/13; **ARC 1054C**, IAB 10/2/13, effective 11/6/13]

441—78.4(249A) Dentists. Payment will be made for medical and surgical services furnished by a dentist to the extent these services may be performed under state law either by doctors of medicine, osteopathy, dental surgery or dental medicine and would be covered if furnished by doctors of medicine or osteopathy. Services must be reasonable, necessary, and cost-effective for the prevention, diagnosis, and treatment of dental disease or injuries or for oral devices necessary for a medical condition. Payment will also be made for the following dental procedures:

78.4(1) Preventive services. Payment shall be made for the following preventive services:

a. Oral prophylaxis, including necessary scaling and polishing, is payable only once in a six-month period except for persons who, because of a physical or mental condition, need more frequent care. Documentation supporting the need for oral prophylaxis performed more than once in a six-month period must be maintained.

b. Topical application of fluoride is payable once every 90 days. (This does not include the use of fluoride prophylaxis paste as fluoride treatment.)

c. Pit and fissure sealants are payable for placement on deciduous and permanent posterior teeth only. Reimbursement for sealants is restricted to work performed on members through 18 years of age and on members who have a physical or mental condition that impairs their ability to maintain adequate oral hygiene. Replacement sealants are covered when medically necessary, as documented in the patient record.

d. Space management services are payable in mixed dentition when premature loss of teeth would permit existing teeth to shift and cause a handicapping malocclusion or there is too little dental ridge to accommodate either the number or the size of teeth and significant dental disease will result if the condition is not corrected.

78.4(2) Diagnostic services. Payment shall be made for the following diagnostic services:

a. A comprehensive oral evaluation is payable once per member per dental practice in a three-year period when the member has not been seen by a dentist in the dental practice during the three-year period.

b. A periodic oral examination is payable once in a six-month period.

c. A full mouth radiograph survey, consisting of a minimum of 14 periapical films and bite-wing films, or a panoramic radiograph with bite-wings is a payable service once in a five-year period, except when medically necessary to evaluate development and to detect anomalies, injuries and diseases. Full mouth radiograph surveys are not payable under the age of six except when medically necessary. A panoramic-type radiography with bite-wings is considered the same as a full mouth radiograph survey.

d. Supplemental bitewing films are payable only once in a 12-month period.

e. Single periapical films are payable when necessary.

f. Intraoral radiograph, occlusal.

g. Extraoral radiograph.

h. Posterior-anterior and lateral skull and facial bone radiograph, survey film.

i. Temporomandibular joint radiograph.

j. Cephalometric film.

k. Diagnostic casts are payable only for orthodontic cases or dental implants or when requested by the Iowa Medicaid enterprise medical services unit's dental consultant.

l. Cone beam images are payable when medically necessary for situations including, but not limited to, detection of tumors, positioning of severely impacted teeth, supernumerary teeth or dental implants.

78.4(3) Restorative services. Payment shall be made for the following restorative services:

a. Treatment of dental caries is payable in those areas which require immediate attention. Restoration of incipient or nonactive carious lesions are not payable. Carious activity may be considered incipient when there is no penetration of the dento-enamel junction as demonstrated in diagnostic radiographs.

b. Amalgam alloy and composite resin-type filling materials are reimbursable only once for the same restoration in a two-year period.

c. Rescinded IAB 5/1/02, effective 7/1/02.

d. Crowns are payable when there is at least a fair prognosis for maintaining the tooth as determined by the Iowa Medicaid enterprise medical services unit and a more conservative procedure would not be serviceable.

(1) Stainless steel crowns are limited to primary and permanent posterior teeth and are covered when coronal loss of tooth structure does not allow restoration with an amalgam or composite restoration. Placement on permanent posterior teeth is allowed only for members who have a mental or physical condition that limits their ability to tolerate the procedure for placement of a different crown.

(2) Aesthetic coated stainless steel crowns and stainless steel crowns with a resin window are limited to primary anterior teeth.

(3) Laboratory-fabricated crowns, other than stainless steel, are limited to permanent teeth and require prior authorization. Approval shall be granted when coronal loss of tooth structure does not allow restoration with an amalgam or composite restoration or there is evidence of recurring decay surrounding a large existing restoration, a fracture, a broken cusp(s), or an endodontic treatment.

(4) Crowns with noble or high noble metals require prior authorization. Approval shall be granted for members who meet the criteria for a laboratory-fabricated crown, other than stainless steel, and who have a documented allergy to all other restorative materials.

e. Cast post and core, post and composite or post and amalgam in addition to a crown are payable when a tooth is functional and the integrity of the tooth would be jeopardized by no post support.

f. Payment as indicated will be made for the following restoration procedures:

(1) Amalgam or acrylic buildups, including any pins, are considered a core buildup.

(2) One, two, or more restorations on one surface of a tooth shall be paid as a one-surface restoration, i.e., mesial occlusal pit and distal occlusal pit of a maxillary molar or mesial and distal occlusal pits of a lower bicuspid.

(3) Occlusal lingual groove of a maxillary molar that extends from the distal occlusal pit and down the distolingual groove will be paid as a two-surface restoration. This restoration and a mesial occlusal pit restoration on the same tooth will be paid as one, two-surface restoration.

(4) Rescinded IAB 5/1/02, effective 7/1/02.

(5) Two separate one-surface restorations are payable as a two-surface restoration (i.e., an occlusal pit restoration and a buccal pit restoration are a two-surface restoration).

(6) Tooth preparation, temporary restorations, cement bases, pulp capping, impressions, and local anesthesia are included in the restorative fee and may not be billed separately.

(7) Pin retention will be paid on a per-tooth basis and in addition to the final restoration.

(8) More than four surfaces on an amalgam restoration will be reimbursed as a “four-surface” amalgam.

(9) An amalgam or composite restoration is not payable following a sedative filling in the same tooth unless the sedative filling was placed more than 30 days previously.

78.4(4) Periodontal services. Payment may be made for the following periodontal services:

a. Full-mouth debridement to enable comprehensive periodontal evaluation and diagnosis is payable once every 24 months. This procedure is not payable on the same date of service when other prophylaxis or periodontal services are performed.

b. Periodontal scaling and root planing is payable once every 24 months when prior approval has been received. Prior approval shall be granted per quadrant when radiographs demonstrate subgingival calculus or loss of crestal bone and when the periodontal probe chart shows evidence of pocket depths of 4 mm or greater. (Cross-reference 78.28(2) “a”(1))

c. Periodontal surgical procedures which include gingivoplasty, osseous surgery, and osseous allograft are payable services when prior approval has been received. Payment for these surgical procedures will be approved after periodontal scaling and root planing has been provided, a reevaluation examination has been completed, and the member has demonstrated reasonable oral hygiene. Payment is also allowed for members who are unable to demonstrate reasonable oral hygiene due to a physical or mental condition, or who exhibit evidence of gingival hyperplasia, or who have a deep carious lesion that cannot be otherwise accessed for restoration.

d. Tissue grafts. Pedicle soft tissue graft, free soft tissue graft, and subepithelial connective tissue graft are payable services with prior approval. Authorization shall be granted when the amount of tissue loss is causing problems such as continued bone loss, chronic root sensitivity, complete loss of attached tissue, or difficulty maintaining adequate oral hygiene. (Cross-reference 78.28(2) “a”(2))

e. Periodontal maintenance therapy requires prior authorization. Approval shall be granted for members who have completed periodontal scaling and root planing at least three months prior to the initial periodontal maintenance therapy and the periodontal probe chart shows evidence of pocket depths of 4 mm or greater. (Cross-reference 78.28(2) “a”(3))

f. Tissue regeneration procedures require prior authorization. Approval shall be granted when radiographs show evidence of recession in relation to the muco-gingival junction and the bone level indicates the tooth has a fair to good long-term prognosis.

g. Localized delivery of antimicrobial agents requires prior authorization. Approval shall be granted when at least one year has elapsed since periodontal scaling and root planing was completed,

the member has maintained regular periodontal maintenance, and pocket depths remain at a moderate to severe depth with bleeding on probing. Authorization is limited to once per site every 12 months.

78.4(5) Endodontic services. Payment shall be made for the following endodontic services:

a. Root canal treatments on permanent anterior and posterior teeth when there is presence of extensive decay, infection, draining fistulas, severe pain upon chewing or applied pressure, prolonged sensitivity to temperatures, or a discolored tooth indicative of a nonvital tooth.

b. Vital pulpotomies. Cement bases, pulp capping, and insulating liners are considered part of the restoration and may not be billed separately.

c. Surgical endodontic treatment, including an apicoectomy, performed as a separate surgical procedure; an apicoectomy, performed in conjunction with endodontic procedure; an apical curettage; a root resection; or excision of hyperplastic tissue is payable when nonsurgical treatment has been attempted and a reasonable time of approximately one year has elapsed after which failure has been demonstrated. Surgical endodontic procedures may be indicated when:

(1) Conventional root canal treatment cannot be successfully completed because canals cannot be negotiated, debrided or obturated due to calcifications, blockages, broken instruments, severe curvatures, and dilacerated roots.

(2) Correction of problems resulting from conventional treatment including gross underfilling, perforations, and canal blockages with restorative materials. (Cross-reference 78.28(2)“c”)

d. Endodontic retreatment when prior authorization has been received. Authorization for retreatment of a tooth with previous endodontic treatment shall be granted when the conventional treatment has been completed, a reasonable time has elapsed since the initial treatment, and failure has been demonstrated with a radiograph and narrative history. A reasonable period of time is approximately one year if the treating dentist is the same and may be less if the member must see a different dentist.

78.4(6) Oral surgery—medically necessary. Payment shall be made for medically necessary oral surgery services furnished by dentists to the extent that these services may be performed under state law either by doctors of medicine, osteopathy, dental surgery or dental medicine and would be covered if furnished by doctors of medicine or osteopathy, as defined in rule 441—78.1(249A). These services will be reimbursed in a manner consistent with the physician’s reimbursement policy. The following surgical procedures are also payable when performed by a dentist:

a. Extractions, both surgical and nonsurgical.

b. Impaction (soft tissue impaction, upper or lower) that requires an incision of overlying soft tissue and the removal of the tooth.

c. Impaction (partial bony impaction, upper or lower) that requires incision of overlying soft tissue, elevation of a flap, removal of bone and removal of the tooth.

d. Impaction (complete bony impaction, upper or lower) that requires incision of overlying soft tissue, elevation of a flap, removal of bone and section of the tooth for removal.

e. Root recovery (surgical removal of residual root).

f. Oral antral fistula closure (or antral root recovery).

g. Surgical exposure of impacted or unerupted tooth for orthodontic reasons, including ligation when indicated.

h. Surgical exposure of impacted or unerupted tooth to aid eruption.

i. Routine postoperative care is considered part of the fee for surgical procedures and may not be billed separately.

j. Payment may be made for postoperative care where need is shown to be beyond normal follow-up care or for postoperative care where the original service was performed by another dentist.

78.4(7) Prosthetic services. Payment may be made for the following prosthetic services:

a. An immediate denture or a first-time complete denture. Six months’ postdelivery care is included in the reimbursement for the denture.

b. A removable partial denture replacing anterior teeth when prior approval has been received. Approval shall be granted when radiographs demonstrate adequate space for replacement of a missing anterior tooth. Six months’ postdelivery care is included in the reimbursement for the denture.

c. A removable partial denture replacing posterior teeth including six months' postdelivery care when prior approval has been received. Approval shall be granted when the member has fewer than eight posterior teeth in occlusion, excluding third molars, or the member has a full denture in one arch and a partial denture replacing posterior teeth is required in the opposing arch to balance occlusion. When one removable partial denture brings eight posterior teeth in occlusion, no additional removable partial denture will be approved. Six months' postdelivery care is included in the reimbursement for the denture. (Cross-reference 78.28(2) "b"(1))

d. A fixed partial denture (including an acid etch fixed partial denture) replacing anterior teeth when prior approval has been received. Approval shall be granted for members who:

- (1) Have a physical or mental condition that precludes the use of a removable partial denture, or
- (2) Have an existing bridge that needs replacement due to breakage or extensive, recurrent decay.

High noble or noble metals shall be approved only when the member is allergic to all other restorative materials. (Cross-reference 78.28(2) "b"(2))

e. A fixed partial denture replacing posterior teeth when prior approval has been received. Approval shall be granted for members who meet the criteria for a removable partial denture and:

- (1) Have a physical or mental condition that precludes the use of a removable partial denture, or
- (2) Have a full denture in one arch and a partial fixed denture replacing posterior teeth is required in the opposing arch to balance occlusion.

High noble or noble metals will be approved only when the member is allergic to all other restorative materials.

f. Obturator for surgically excised palatal tissue or deficient velopharyngeal function of cleft palate patients.

g. Chairside relines and laboratory-processed relines are payable only once per prosthesis every 12 months, beginning 6 months after placement of the denture.

h. Tissue conditioning is a payable service twice per prosthesis in a 12-month period.

i. Two repairs per prosthesis in a 12-month period are payable.

j. Adjustments to a complete or removable partial denture are payable when medically necessary after six months' postdelivery care. An adjustment consists of removal of acrylic material or adjustment of teeth to eliminate a sore area or to make the denture fit better. Warming dentures and massaging them for better fit or placing them in a sonic device does not constitute an adjustment.

k. Dental implants and related services when prior authorization has been received. Prior authorization shall be granted when the member is missing significant oral structures due to cancer, traumatic injuries, or developmental defects such as cleft palate and cannot use a conventional denture.

l. Replacement of complete or partial dentures in less than a five-year period requires prior authorization. Approval shall be granted once per denture replacement per arch in a five-year period when the denture has been lost, stolen or broken beyond repair or cannot be adjusted for an adequate fit. Approval shall also be granted for more than one denture replacement per arch within five years for members who have a medical condition that necessitates thorough mastication. Approval will not be granted in less than a five-year period when the reason for replacement is resorption.

m. A complete or partial denture rebase requires prior approval. Approval shall be granted when the acrylic of the denture is cracked or has had numerous repairs and the teeth are in good condition.

n. An oral appliance for obstructive sleep apnea requires prior approval and must be custom-fabricated. Approval shall be granted in accordance with Medicare criteria.

78.4(8) Orthodontic procedures. Payment may be made for the following orthodontic procedures:

a. Minor treatment to control harmful habits when prior approval has been received. Approval shall be granted when it is cost-effective to lessen the severity of a malformation such that extensive treatment is not required. (Cross-reference 78.28(2) "c")

b. Interceptive orthodontic treatment of the transitional dentition when prior approval has been received. Approval shall be granted when it is cost-effective to lessen the severity of a malformation such that extensive treatment is not required.

c. Comprehensive orthodontic treatment when prior approval has been received. Approval is limited to members under 21 years of age and shall be granted when the member has a severe

handicapping malocclusion with a score of 26 or above using the index from the “Handicapping Malocclusion Assessment to Establish Treatment Priority,” by J.A. Salzmann, D.D.S., American Journal of Orthodontics, October 1968.

78.4(9) *Adjunctive general services.* Payment may be made for the following:

a. Treatment in a hospital. Payment will be approved for dental treatment rendered to a hospitalized member only when the mental, physical, or emotional condition of the member prevents the dentist from providing necessary care in the office.

b. Treatment in a nursing facility. Payment will be approved for dental treatment provided in a nursing facility. When more than one patient is examined during the same nursing home visit, payment will be made by the Medicaid program for only one visit to the nursing home.

c. Office visit. Payment will be approved for an office visit for care of injuries or abnormal conditions of the teeth or supporting structure when treatment procedures or examinations are not billed for that visit.

d. Office calls after hours. Payment will be approved for office calls after office hours in emergency situations. The office call will be paid in addition to treatment procedures.

e. Drugs. Payment will be made for drugs dispensed by a dentist only if there is no licensed retail pharmacy in the community where the dentist’s office is located. If eligible to dispense drugs, the dentist should request a copy of the Prescribed Drugs Manual from the Iowa Medicaid enterprise provider services unit. Payment will not be made for the writing of prescriptions.

f. Anesthesia. General anesthesia, intravenous sedation, and nonintravenous conscious sedation are payable services when the extensiveness of the procedure indicates it or there is a concomitant disease or impairment which warrants use of anesthesia. Inhalation of nitrous oxide is payable when the age or physical or mental condition of the member necessitates the use of minimal sedation for dental procedures.

g. Occlusal guard. A removable dental appliance to minimize the effects of bruxism and other occlusal factors requires prior approval. Approval shall be granted when the documentation supports evidence of significant loss of tooth enamel, tooth chipping, headaches or jaw pain.

78.4(10) *Orthodontic services to members 21 years of age or older.* Orthodontic procedures are not covered for members 21 years of age or older.

This rule is intended to implement Iowa Code section 249A.4.

[ARC 9702B, IAB 9/7/11, effective 9/1/11; ARC 9883B, IAB 11/30/11, effective 1/4/12; ARC 0631C, IAB 3/6/13, effective 5/1/13]

441—78.5(249A) Podiatrists. Payment will be approved only for certain podiatric services.

78.5(1) Payment will be approved for the following orthotic appliances and treatment of nail pathologies:

a. Durable plantar foot orthotic.

b. Plaster impressions for foot orthotic.

c. Molded digital orthotic.

d. Shoe padding when appliances are not practical.

e. Custom molded space shoes for rheumatoid arthritis, congenital defects and deformities, neurotropic, diabetic and ischemic intractable ulcerations and deformities due to injuries.

f. Rams horn (hypertrophic) nails.

g. Onychomycosis (mycotic) nails.

78.5(2) Payment will be made for the same scope of podiatric services available through Part B of Title XVIII (Medicare) except as listed below:

a. Treatment of flatfoot. The term “flatfoot” is defined as a condition in which one or more arches have flattened out.

b. Treatment of subluxations of the foot are defined as partial dislocations or displacements of joint surfaces, tendons, ligaments, or muscles of the foot. Surgical or nonsurgical treatments undertaken for the sole purpose of correcting a subluxated structure in the foot as an isolated entity are not covered.

Reasonable and necessary diagnosis of symptomatic conditions that result from or are associated with partial displacement of foot structures is a covered service. Surgical correction in the subluxated

foot structure that is an integral part of the treatment of a foot injury or is undertaken to improve the function of the foot or to alleviate an induced or associated symptomatic condition is a covered service.

c. Routine foot care. Routine foot care includes the cutting or removal of corns or callouses, the trimming of nails and other hygienic and preventive maintenance care in the realm of self-care such as cleaning and soaking the feet, the use of skin creams to maintain skin tone of both ambulatory and bedfast patients and any services performed in the absence of localized illness, injury, or symptoms involving the foot.

d. Orthopedic shoes. Payment will not be made for orthopedic shoes or for any device to be worn in or attached to orthopedic shoes or other types of shoes when provided by the podiatrist. Payment will be made to the podiatrist for the examination including tests to establish the need for orthopedic shoes.

78.5(3) Prescriptions are required for drugs and supplies as specified in paragraph 78.1(2)“c.” Payment shall be made for drugs dispensed by a podiatrist only if there is no licensed retail pharmacy in the community where the podiatrist’s office is located. If eligible to dispense drugs, the podiatrist should request a copy of the Prescribed Drugs Manual from the Iowa Medicaid enterprise provider services unit. Payment will not be made for writing prescriptions.

This rule is intended to implement Iowa Code section 249A.4.

441—78.6(249A) Optometrists. Payment will be approved for medically necessary services and supplies provided by the optometrist within the scope of practice of optometry and the limitations of state law, subject to the following limitations and exclusions. Covered optometric services include a professional component and materials.

78.6(1) Payable professional services. Payable professional services are:

a. Eye examinations. The coverage of eye examinations depends on the purpose of the examination. Services are covered if the examination is the result of a complaint or symptom of an eye disease or injury. Routine eye examinations are covered once in a 12-month period. These services are rendered in the optometrist’s office or clinic, the home, a nursing facility, or other appropriate setting. Payment for mileage shall be subject to the same approval and payment criteria as those in effect for Medicare Part B. The following levels of service are recognized for optometric examinations:

(1) Intermediate examination. A level of optometric or ophthalmological services pertaining to medical examination and evaluation, with initiation or continuation of a diagnostic and treatment program.

(2) Comprehensive examination. A level of optometric or ophthalmological services pertaining to medical examination and evaluation, with initiation or continuation of a diagnostic and treatment program, and a general evaluation of the complete visual system.

b. Medical services. Payment will be approved for medically necessary services and supplies within the scope of practice of the optometrist, including services rendered in the optometrist’s office or clinic, the home, a nursing facility, or other appropriate setting. Payment for mileage shall be subject to the same approval and payment criteria as those in effect for Medicare Part B.

c. Auxiliary procedures. The following auxiliary procedures and special tests are payable when performed by an optometrist. Auxiliary procedures and special tests are reimbursed as a separate procedure only when warranted by case history or diagnosis.

(1) Serial tonometry. Single tonometry is part of the intermediate and comprehensive exams and is not payable as a separate procedure as is serial tonometry.

(2) Gonioscopy.

(3) Extended ophthalmoscopy. Routine ophthalmoscopy is part of the intermediate and comprehensive examination and is not payable as a separate procedure. Generally, extended ophthalmoscopy is considered to be part of the comprehensive examination and, if performed in conjunction with that level of service, is not payable as a separate procedure.

(4) Visual fields. Gross visual field testing is part of general optometric services and is not reported separately.

(5) External photography.

(6) Fundus photography.

- (7) Retinal integrity evaluation with a three-mirror lens.
- d.* Single vision and multifocal spectacle lens service, verification and subsequent service. When lenses are necessary, the following enumerated professional and technical optometric services are to be provided:
- (1) When spectacle lenses are necessary, the following enumerated professional and technical optometric services are to be provided:
1. Ordering of corrective lenses.
 2. Verification of lenses after fabrication.
 3. Adjustment and alignment of completed lens order.
- (2) New spectacle lenses are subject to the following limitations:
1. Up to three times for children up to one year of age.
 2. Up to four times per year for children one through three years of age.
 3. Once every 12 months for children four through seven years of age.
 4. Once every 24 months after eight years of age when there is a change in the prescription.
- (3) Spectacle lenses made from polycarbonate or equivalent material are allowed for:
1. Children through seven years of age.
 2. Members with vision in only one eye.
 3. Members with a diagnosis-related illness or disability where regular lenses would pose a safety risk.
- e.* Rescinded IAB 4/3/02, effective 6/1/02.
- f.* Frame service.
- (1) When a new frame is necessary, the following enumerated professional and technical optometric services are to be provided:
1. Selection and styling.
 2. Sizing and measurements.
 3. Fitting and adjustment.
 4. Readjustment and servicing.
- (2) New frames are subject to the following limitations:
1. One frame every six months is allowed for children through three years of age.
 2. One frame every 12 months is allowed for children four through seven years of age.
 3. When there is a covered lens change and the new lenses cannot be accommodated by the current frame.
- (3) Safety frames are allowed for:
1. Children through seven years of age.
 2. Members with a diagnosis-related disability or illness where regular frames would pose a safety risk or result in frequent breakage.
- g.* Rescinded IAB 4/3/02, effective 6/1/02.
- h.* Repairs or replacement of frames, lenses or component parts. Payment shall be made for service in addition to materials. The service fee shall not exceed the dispensing fee for a replacement frame. Payment shall be made for replacement of glasses when the original glasses have been lost or damaged beyond repair. Replacement of lost or damaged glasses is limited to one pair of frames and two lenses once every 12 months for adults aged 21 and over, except for people with a mental or physical disability.
- i.* Contact lenses. Payment shall be made for documented keratoconus, aphakia, high myopia, anisometropia, trauma, severe ocular surface disease, irregular astigmatism, for treatment of acute or chronic eye disease, or when the member's vision cannot be adequately corrected with spectacle lenses. Contact lenses are subject to the following limitations:
- (1) Up to 16 gas permeable contact lenses are allowed for children up to one year of age.
 - (2) Up to 8 gas permeable contact lenses are allowed every 12 months for children one through three years of age.
 - (3) Up to 6 gas permeable contact lenses are allowed every 12 months for children four through seven years of age.

(4) Two gas permeable contact lenses are allowed every 24 months for members eight years of age or older.

(5) Soft contact lenses and replacements are allowed when medically necessary.

78.6(2) *Ophthalmic materials.* Ophthalmic materials which are provided in connection with any of the foregoing professional optometric services shall provide adequate vision as determined by the optometrist and meet the following standards:

- a.* Corrected curve lenses, unless clinically contraindicated.
- b.* Standard plastic, plastic and metal combination, or metal frames.
- c.* Prescription standards according to the American National Standards Institute (ANSI) standards and tolerance.

78.6(3) *Reimbursement.* The reimbursement for allowed ophthalmic material is subject to a fee schedule established by the department or to actual laboratory cost as evidenced by an attached invoice. Reimbursement for rose tint is included in the fee for the lenses.

a. Materials payable by fee schedule are:

- (1) Spectacle lenses, single vision and multifocal.
- (2) Frames.
- (3) Case for glasses.

b. Materials payable at actual laboratory cost as evidenced by an attached invoice are:

- (1) Contact lenses.
- (2) Schroeder shield.
- (3) Ptosis crutch.
- (4) Safety frames.
- (5) Subnormal visual aids.
- (6) Photochromatic lenses.

78.6(4) *Prior authorization.* Prior authorization is required for the following:

a. A second lens correction within a 24-month period for members eight years of age and older. Approval shall be given when the member's vision has at least a five-tenths diopter of change in sphere or cylinder or ten-degree change in axis in either eye.

b. Visual therapy may be authorized when warranted by case history or diagnosis for a period of time not greater than 90 days. Should continued therapy be warranted, the prior approval process shall be reaccomplished, accompanied by a report showing satisfactory progress. Approved diagnoses are convergence insufficiency and amblyopia. Visual therapy is not covered when provided by opticians.

c. Subnormal visual aids where near visual acuity is at or better than 20/100 at 16 inches, 2M print. Prior authorization is not required if near visual acuity as described above is less than 20/100. Subnormal visual aids include, but are not limited to, hand magnifiers, loupes, telescopic spectacles, or reverse Galilean telescope systems. Payment shall be actual laboratory cost as evidenced by an attached invoice.

d. Approval for photochromatic tint shall be given when the member has a documented medical condition that causes photosensitivity and less costly alternatives are inadequate.

e. Approval for press-on prisms shall be granted for members whose vision cannot be adequately corrected with other covered prisms.

(Cross-reference 78.28(3))

78.6(5) *Noncovered services.* Noncovered services include, but are not limited to, the following services:

- a.* Glasses with cosmetic gradient tint lenses or other eyewear for cosmetic purposes.
- b.* Glasses for occupational eye safety.
- c.* A second pair of glasses or spare glasses.
- d.* Cosmetic surgery and experimental medical and surgical procedures.
- e.* Sunglasses.
- f.* Progressive bifocal or trifocal lenses.

78.6(6) *Therapeutically certified optometrists.* Rescinded IAB 9/5/12, effective 11/1/12.

This rule is intended to implement Iowa Code section 249A.4.

[ARC 7548B, IAB 2/11/09, effective 4/1/09; ARC 0305C, IAB 9/5/12, effective 11/1/12]

441—78.7(249A) Opticians. Payment will be approved only for certain services and supplies provided by opticians when prescribed by a physician (MD or DO) or an optometrist. Payment and procedure for obtaining services and supplies shall be the same as described in rule 441—78.6(249A). (Cross-reference 78.28(3))

78.7(1) to 78.7(3) Rescinded IAB 4/3/02, effective 6/1/02.

This rule is intended to implement Iowa Code section 249A.4.

441—78.8(249A) Chiropractors. Payment will be made for the same chiropractic procedures payable under Title XVIII of the Social Security Act (Medicare).

78.8(1) *Covered services.* Chiropractic manipulative therapy (CMT) eligible for reimbursement is specifically limited by Medicaid to the manual manipulation (i.e., by use of the hands) of the spine for the purpose of correcting a subluxation demonstrated by X-ray. Subluxation means an incomplete dislocation, off-centering, misalignment, fixation, or abnormal spacing of the vertebrae.

78.8(2) *Indications and limitations of coverage.*

a. The subluxation must have resulted in a neuromusculoskeletal condition set forth in the table below for which CMT is appropriate treatment. The symptoms must be directly related to the subluxation that has been diagnosed. The mere statement or diagnosis of “pain” is not sufficient to support the medical necessity of CMT. CMT must have a direct therapeutic relationship to the patient’s condition. No other diagnostic or therapeutic service furnished by a chiropractor is covered under the Medicaid program.

ICD-9	CATEGORY I	ICD-9	CATEGORY II	ICD-9	CATEGORY III
307.81	Tension headache	353.0	Brachial plexus lesions	721.7	Traumatic spondylopathy
721.0	Cervical spondylosis without myelopathy	353.1	Lumbosacral plexus lesions	722.0	Displacement of cervical intervertebral disc without myelopathy
721.2	Thoracic spondylosis without myelopathy	353.2	Cervical root lesions, NEC	722.10	Displacement of lumbar intervertebral disc without myelopathy
721.3	Lumbosacral spondylosis without myelopathy	353.3	Thoracic root lesions, NEC	722.11	Displacement of thoracic intervertebral disc without myelopathy
723.1	Cervicalgia	353.4	Lumbosacral root lesions, NEC	722.4	Degeneration of cervical intervertebral disc
724.1	Pain in thoracic spine	353.8	Other nerve root and plexus disorders	722.51	Degeneration of thoracic or thoracolumbar intervertebral disc
724.2	Lumbago	719.48	Pain in joint (other specified sites, must specify site)	722.52	Degeneration of lumbar or lumbosacral intervertebral disc
724.5	Backache, unspecified	720.1	Spinal enthesopathy	722.81	Post laminectomy syndrome, cervical region
784.0	Headache	722.91	Calcification of intervertebral cartilage or disc, cervical region	722.82	Post laminectomy syndrome, thoracic region
		722.92	Calcification of intervertebral cartilage or disc, thoracic region	722.83	Post laminectomy syndrome, lumbar region
		722.93	Calcification of intervertebral cartilage or disc, lumbar region	724.3	Sciatica
		723.0	Spinal stenosis in cervical region		
		723.2	Cervicocranial syndrome		

ICD-9 CATEGORY I	ICD-9 CATEGORY II	ICD-9 CATEGORY III
	723.3 Cervicobrachial syndrome	
	723.4 Brachial neuritis or radiculitis, NOC	
	723.5 Torticollis, unspecified	
	724.01 Spinal stenosis, thoracic region	
	724.02 Spinal stenosis, lumbar region	
	724.4 Thoracic or lumbosacral neuritis or radiculitis	
	724.6 Disorders of sacrum, ankylosis	
	724.79 Disorders of coccyx, coccygodynia	
	724.8 Other symptoms referable to back, facet syndrome	
	729.1 Myalgia and myositis, unspecified	
	729.4 Fascitis, unspecified	
	738.40 Acquired spondylolisthesis	
	756.12 Spondylolisthesis	
	846.0 Sprains and strains of sacroiliac region, lumbosacral (joint; ligament)	
	846.1 Sprains and strains of sacroiliac region, sacroiliac ligament	
	846.2 Sprains and strains of sacroiliac region, sacrospinatus (ligament)	
	846.3 Sprains and strains of sacroiliac region, sacrotuberous (ligament)	
	846.8 Sprains and strains of sacroiliac region, other specified sites of sacroiliac region	
	847.0 Sprains and strains, neck	
	847.1 Sprains and strains, thoracic	
	847.2 Sprains and strains, lumbar	
	847.3 Sprains and strains, sacrum	
	847.4 Sprains and strains, coccyx	

b. The neuromusculoskeletal conditions listed in the table in paragraph “*a*” generally require short-, moderate-, or long-term CMT. A diagnosis or combination of diagnoses within Category I generally requires short-term CMT of 12 per 12-month period. A diagnosis or combination of diagnoses within Category II generally requires moderate-term CMT of 18 per 12-month period. A diagnosis or combination of diagnoses within Category III generally requires long-term CMT of 24 per 12-month period. For diagnostic combinations between categories, 28 CMTs are generally required per 12-month period. If the CMT utilization guidelines are exceeded, documentation supporting the medical necessity of additional CMT must be submitted with the Medicaid claim form or the claim will be denied for failure to provide information.

- c. CMT is not a covered benefit when:
- (1) The maximum therapeutic benefit has been achieved for a given condition.
 - (2) There is not a reasonable expectation that the continuation of CMT would result in improvement of the patient's condition.

- (3) The CMT seeks to prevent disease, promote health and prolong and enhance the quality of life.

78.8(3) Documenting X-ray. An X-ray must document the primary regions of subluxation being treated by CMT.

a. The documenting X-ray must be taken at a time reasonably proximate to the initiation of CMT. An X-ray is considered to be reasonably proximate if it was taken no more than 12 months prior to or 3 months following the initiation of CMT. X-rays need not be repeated unless there is a new condition and no payment shall be made for subsequent X-rays, absent a new condition, consistent with paragraph "c" of this subrule. No X-ray is required for pregnant women and for children aged 18 and under.

b. The X-ray films shall be labeled with the patient's name and date the X-rays were taken and shall be marked right or left. The X-ray shall be made available to the department or its duly authorized representative when requested. A written and dated X-ray report, including interpretation and diagnosis, shall be present in the patient's clinical record.

c. Chiropractors shall be reimbursed for documenting X-rays at the physician fee schedule rate. Payable X-rays shall be limited to those Current Procedural Terminology (CPT) procedure codes that are appropriate to determine the presence of a subluxation of the spine. Criteria used to determine payable X-ray CPT codes may include, but are not limited to, the X-ray CPT codes for which major commercial payors reimburse chiropractors. The Iowa Medicaid enterprise shall publish in the Chiropractic Services Provider Manual the current list of payable X-ray CPT codes. Consistent with CPT, chiropractors may bill the professional, technical, or professional and technical components for X-rays, as appropriate. Payment for documenting X-rays shall be further limited to one per condition, consistent with the provisions of paragraph "a" of this subrule. A claim for a documenting X-ray related to the onset of a new condition is only payable if the X-ray is reasonably proximate to the initiation of CMT for the new condition, as defined in paragraph "a" of this subrule. A chiropractor is also authorized to order a documenting X-ray whether or not the chiropractor owns or possesses X-ray equipment in the chiropractor's office. Any X-rays so ordered shall be payable to the X-ray provider, consistent with the provisions in this paragraph.

This rule is intended to implement Iowa Code section 249A.4.

441—78.9(249A) Home health agencies. Payment shall be approved for medically necessary home health agency services prescribed by a physician in a plan of home health care provided by a Medicare-certified home health agency.

The number of hours of home health agency services shall be reasonable and appropriate to meet an established medical need of the member that cannot be met by a family member, significant other, friend, or neighbor. Services must be medically necessary in the individual case and be related to a diagnosed medical impairment or disability.

The member need not be homebound to be eligible for home health agency services; however, the services provided by a home health agency shall only be covered when provided in the member's residence with the following exception. Private duty nursing and personal care services for persons aged 20 and under as described at 78.9(10) "a" may be provided in settings other than the member's residence when medically necessary.

Medicaid members of home health agency services need not first require skilled nursing care to be entitled to home health aide services.

Further limitations related to specific components of home health agency services are noted in subrules 78.9(3) to 78.9(10).

Payment shall be made on an encounter basis. An encounter is defined as separately identifiable hours in which home health agency staff provide continuous service to a member.

Payment for supplies shall be approved when the supplies are incidental to the patient's care, e.g., syringes for injections, and do not exceed \$15 per month. Dressings, durable medical equipment, and

other supplies shall be obtained from a durable medical equipment dealer or pharmacy. Payment of supplies may be made to home health agencies when a durable medical equipment dealer or pharmacy is not available in the member's community.

Payment may be made for restorative and maintenance home health agency services.

Payment may be made for teaching, training, and counseling in the provision of health care services.

Treatment plans for these services shall additionally reflect: to whom the services are to be provided (patient, family member, etc.); prior teaching training, or counseling provided; medical necessity for the rendered service; identification of specific services and goals; date of onset of the teaching, training, or counseling; frequency of services; progress of member in response to treatment; and estimated length of time these services will be needed.

The following are not covered: services provided in the home health agency office, homemaker services, well child care and supervision, and medical equipment rental or purchase.

Services shall be authorized by a physician, evidenced by the physician's signature and date on a plan of treatment.

78.9(1) *Treatment plan.* A plan of treatment shall be completed prior to the start of care and at a minimum reviewed every 62 days thereafter. The plan of care shall support the medical necessity and intensity of services to be provided by reflecting the following information:

- a. Place of service.
- b. Type of service to be rendered and the treatment modalities being used.
- c. Frequency of the services.
- d. Assistance devices to be used.
- e. Date home health services were initiated.
- f. Progress of member in response to treatment.
- g. Medical supplies to be furnished.
- h. Member's medical condition as reflected by the following information, if applicable:
 - (1) Dates of prior hospitalization.
 - (2) Dates of prior surgery.
 - (3) Date last seen by a physician.
 - (4) Diagnoses and dates of onset of diagnoses for which treatment is being rendered.
 - (5) Prognosis.
 - (6) Functional limitations.
 - (7) Vital signs reading.
 - (8) Date of last episode of instability.
 - (9) Date of last episode of acute recurrence of illness or symptoms.
 - (10) Medications.
- i. Discipline of the person providing the service.
- j. Certification period (no more than 62 days).
- k. Estimated date of discharge from the hospital or home health agency services, if applicable.
- l. Physician's signature and date. The plan of care must be signed and dated by the physician

before the claim for service is submitted for reimbursement.

78.9(2) *Supervisory visits.* Payment shall be made for supervisory visits two times a month when a registered nurse acting in a supervisory capacity provides supervisory visits of services provided by a home health aide under a home health agency plan of treatment or when services are provided by an in-home health care provider under the department's in-home health-related care program as set forth in 441—Chapter 177.

78.9(3) *Skilled nursing services.* Skilled nursing services are services that when performed by a home health agency require a licensed registered nurse or licensed practical nurse to perform. Situations when a service can be safely performed by the member or other nonskilled person who has received the proper training or instruction or when there is no one else to perform the service are not considered a "skilled nursing service." Skilled nursing services shall be available only on an intermittent basis. Intermittent services for skilled nursing services shall be defined as a medically predictable recurring need requiring a skilled nursing service at least once every 60 days, not to exceed five days per week

(except as provided below), with an attempt to have a predictable end. Daily visits (six or seven days per week) that are reasonable and necessary and show an attempt to have a predictable end shall be covered for up to three weeks. Coverage of additional daily visits beyond the initial anticipated time frame may be appropriate for a short period of time, based on the medical necessity of service. Medical documentation shall be submitted justifying the need for continued visits, including the physician's estimate of the length of time that additional visits will be necessary. Daily skilled nursing visits or multiple daily visits for wound care or insulin injections shall be covered when ordered by a physician and included in the plan of care. Other daily skilled nursing visits which are ordered for an indefinite period of time and designated as daily skilled nursing care do not meet the intermittent definition and shall be denied.

Skilled nursing services shall be evaluated based on the complexity of the service and the condition of the patient.

Private duty nursing for persons aged 21 and over is not a covered service. See subrule 78.9(10) for guidelines for private duty nursing for persons aged 20 or under.

78.9(4) *Physical therapy services.* Payment shall be made for physical therapy services when the services relate directly to an active written treatment plan, follow a treatment plan established by the physician after any needed consultation with the qualified physical therapist, are reasonable and necessary to the treatment of the patient's illness or injury, and meet the guidelines defined for restorative, maintenance, or trial therapy as set forth in subrule 78.19(1), paragraphs "a" and "b."

For physical therapy services, the treatment plan shall additionally reflect goals, modalities of treatment, date of onset of conditions being treated, restorative potential, and progress notes.

78.9(5) *Occupational therapy services.* Payment shall be made for occupational therapy services when the services relate directly to an active written treatment plan, follow a treatment plan established by the physician, are reasonable and necessary to the treatment of the patient's illness or injury, and meet the guidelines defined for restorative, maintenance, or trial therapy as set forth in subrule 78.19(1), paragraphs "a" and "c."

For occupational therapy services, the treatment plan shall additionally reflect goals, modalities of treatment, date of onset of conditions being treated, restorative potential, and progress notes.

78.9(6) *Speech therapy services.* Payment shall be made for speech therapy services when the services relate directly to an active written treatment plan, follow a treatment plan established by the physician, are reasonable and necessary to the treatment of the patient's illness or injury, and meet the guidelines defined for restorative, maintenance, or trial therapy as set forth in subrule 78.19(1), paragraphs "a" and "d."

For speech therapy services, the treatment plan shall additionally reflect goals, modalities of treatment, date of onset of conditions being treated, restorative potential, and progress notes.

78.9(7) *Home health aide services.* Payment shall be made for unskilled services provided by a home health aide if the following conditions are met:

a. The service as well as the frequency and duration are stated in a written plan of treatment established by a physician. The home health agency is encouraged to collaborate with the member, or in the case of a child with the child's caregiver, in the development and implementation of the plan of treatment.

b. The member requires personal care services as determined by a registered nurse or other appropriate therapist. The services shall be given under the supervision of a registered nurse, physical, speech, or occupational therapist and the registered nurse or therapist shall assign the aide who will provide the care.

c. Services shall be provided on an intermittent basis. "Intermittent basis" for home health agency services is defined as services that are usually two to three times a week for two to three hours at a time. Services provided for four to seven days per week, not to exceed 28 hours per week, when ordered by a physician and included in a plan of care shall be allowed as intermittent services. Increased services provided when medically necessary due to unusual circumstances on a short-term basis of two to three weeks may also be allowed as intermittent services when the home health agency documents the need for the excessive time required for home health aide services.

Home health aide daily care may be provided for persons employed or attending school whose disabling conditions require the persons to be assisted with morning and evening activities of daily living in order to support their independent living.

Personal care services include the activities of daily living, e.g., helping the member to bathe, get in and out of bed, care for hair and teeth, exercise, and take medications specifically ordered by the physician, but ordinarily self-administered, and retraining the member in necessary self-help skills.

Certain household services may be performed by the aide in order to prevent or postpone the member's institutionalization when the primary need of the member for home health aide services furnished is for personal care. If household services are incidental and do not substantially increase the time spent by the aide in the home, the entire visit is considered a covered service. Domestic or housekeeping services which are not related to patient care are not a covered service if personal care is not rendered during the visit.

For home health aide services, the treatment plan shall additionally reflect the number of hours per visit and the living arrangement of the member, e.g., lives alone or with family.

78.9(8) *Medical social services.*

a. Payment shall be made for medical social work services when all of the following conditions are met and the problems are not responding to medical treatment and there does not appear to be a medical reason for the lack of response. The services:

- (1) Are reasonable and necessary to the treatment of a member's illness or injury.
- (2) Contribute meaningfully to the treatment of the member's condition.
- (3) Are under the direction of a physician.
- (4) Are provided by or under the supervision of a qualified medical or psychiatric social worker.
- (5) Address social problems that are impeding the member's recovery.

b. Medical social services directed toward minimizing the problems an illness may create for the member and family, e.g., encouraging them to air their concerns and providing them with reassurance, are not considered reasonable and necessary to the treatment of the patient's illness or injury.

78.9(9) *Home health agency care for maternity patients and children.* The intent of home health agency services for maternity patients and children shall be to provide services when the members are unable to receive the care outside of their home and require home health care due to a high-risk factor. Routine prenatal, postpartum, or child health care is a covered service in a physician's office or clinic and, therefore, is not covered by Medicaid when provided by a home health agency.

a. Treatment plans for maternity patients and children shall identify:

- (1) The potential risk factors,
- (2) The medical factor or symptom which verifies the child is at risk,
- (3) The reason the member is unable to obtain care outside of the home,
- (4) The medically related task of the home health agency,
- (5) The member's diagnosis,
- (6) Specific services and goals, and
- (7) The medical necessity for the services to be rendered. A single high-risk factor does not provide

sufficient documentation of the need for services.

b. The following list of potential high-risk factors may indicate a need for home health services to prenatal maternity patients:

- (1) Aged 16 or under.
- (2) First pregnancy for a woman aged 35 or over.
- (3) Previous history of prenatal complications such as fetal death, eclampsia, C-section delivery, psychosis, or diabetes.
- (4) Current prenatal problems such as hypertensive disorders of pregnancy, diabetes, cardiac disease, sickle cell anemia, low hemoglobin, mental illness, or drug or alcohol abuse.
- (5) Sociocultural or ethnic problems such as language barriers, lack of family support, insufficient dietary practices, history of child abuse or neglect, or single mother.
- (6) Preexisting disabilities such as sensory deficits, or mental or physical disabilities.
- (7) Second pregnancy in 12 months.

(8) Death of a close family member or significant other within the previous year.

c. The following list of potential high-risk factors may indicate a need for home health services to postpartum maternity patients:

- (1) Aged 16 or under.
- (2) First pregnancy for a woman aged 35 or over.
- (3) Major postpartum complications such as severe hemorrhage, eclampsia, or C-section delivery.
- (4) Preexisting mental or physical disabilities such as deaf, blind, hemaplegic, activity-limiting disease, sickle cell anemia, uncontrolled hypertension, uncontrolled diabetes, mental illness, or mental retardation.
- (5) Drug or alcohol abuse.
- (6) Symptoms of postpartum psychosis.
- (7) Special sociocultural or ethnic problems such as lack of job, family problems, single mother, lack of support system, or history of child abuse or neglect.
- (8) Demonstrated disturbance in maternal and infant bonding.
- (9) Discharge or release from hospital against medical advice before 36 hours postpartum.
- (10) Insufficient antepartum care by history.
- (11) Multiple births.
- (12) Nonhospital delivery.

d. The following list of potential high-risk factors may indicate a need for home health services to infants:

- (1) Birth weight of five pounds or under or over ten pounds.
- (2) History of severe respiratory distress.
- (3) Major congenital anomalies such as neonatal complications which necessitate planning for long-term follow-up such as postsurgical care, poor prognosis, home stimulation activities, or periodic development evaluation.
- (4) Disabling birth injuries.
- (5) Extended hospitalization and separation from other family members.
- (6) Genetic disorders, such as Down's syndrome, and phenylketonuria or other metabolic conditions that may lead to mental retardation.
- (7) Noted parental rejection or indifference toward baby such as never visiting or calling the hospital about the baby's condition during the infant's extended stay.
- (8) Family sociocultural or ethnic problems such as low education level or lack of knowledge of child care.
- (9) Discharge or release against medical advice before 36 hours of age.
- (10) Nutrition or feeding problems.

e. The following list of potential high-risk factors may indicate a need for home health services to preschool or school-age children:

- (1) Child or sibling victim of child abuse or neglect.
- (2) Mental retardation or other physical disabilities necessitating long-term follow-up or major readjustments in family lifestyle.
- (3) Failure to complete the basic series of immunizations by 18 months, or boosters by 6 years.
- (4) Chronic illness such as asthma, cardiac, respiratory or renal disease, diabetes, cystic fibrosis, or muscular dystrophy.
- (5) Malignancies such as leukemia or carcinoma.
- (6) Severe injuries necessitating treatment or rehabilitation.
- (7) Disruption in family or peer relationships.
- (8) Suspected developmental delay.
- (9) Nutritional deficiencies.

78.9(10) *Private duty nursing or personal care services for persons aged 20 and under.* Payment for private duty nursing or personal care services for persons aged 20 and under shall be approved if determined to be medically necessary. Payment shall be made on an hourly unit of service.

a. Definitions.

(1) Private duty nursing services are those services which are provided by a registered nurse or a licensed practical nurse under the direction of the member's physician to a member in the member's place of residence or outside the member's residence, when normal life activities take the member outside the place of residence. Place of residence does not include nursing facilities, intermediate care facilities for the mentally retarded, or hospitals.

Services shall be provided according to a written plan of care authorized by a licensed physician. The home health agency is encouraged to collaborate with the member, or in the case of a child with the child's caregiver, in the development and implementation of the plan of treatment. These services shall exceed intermittent guidelines as defined in subrule 78.9(3). Private duty nursing and personal care services shall be inclusive of all home health agency services personally provided to the member. Enhanced payment under the interim fee schedule shall be made available for services to children who are technology dependent, i.e., ventilator dependent or whose medical condition is so unstable as to otherwise require intensive care in a hospital.

Private duty nursing or personal care services do not include:

1. Respite care, which is a temporary intermission or period of rest for the caregiver.
2. Nurse supervision services including chart review, case discussion or scheduling by a registered nurse.
3. Services provided to other persons in the member's household.
4. Services requiring prior authorization that are provided without regard to the prior authorization process.
5. Transportation services.
6. Homework assistance.

(2) Personal care services are those services provided by a home health aide or certified nurse's aide and which are delegated and supervised by a registered nurse under the direction of the member's physician to a member in the member's place of residence or outside the member's residence, when normal life activities take the member outside the place of residence. Place of residence does not include nursing facilities, intermediate care facilities for the mentally retarded, or hospitals. Payment for personal care services for persons aged 20 and under that exceed intermittent guidelines may be approved if determined to be medically necessary as defined in subrule 78.9(7). These services shall be in accordance with the member's plan of care and authorized by a physician. The home health agency is encouraged to collaborate with the member, or in the case of a child with the child's caregiver, in the development and implementation of the plan of treatment.

Medical necessity means the service is reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent the worsening of conditions that endanger life, cause pain, result in illness or infirmity, threaten to cause or aggravate a disability or chronic illness, and no other equally effective course of treatment is available or suitable for the member requesting a service.

b. Requirements.

(1) Private duty nursing or personal care services shall be ordered in writing by a physician as evidenced by the physician's signature on the plan of care.

(2) Private duty nursing or personal care services shall be authorized by the department or the department's designated review agent prior to payment.

(3) Prior authorization shall be requested at the time of initial submission of the plan of care or at any time the plan of care is substantially amended and shall be renewed with the department or the department's designated review agent. Initial request for and request for renewal of prior authorization shall be submitted to the department's designated review agent. The provider of the service is responsible for requesting prior authorization and for obtaining renewal of prior authorization.

The request for prior authorization shall include a nursing assessment, the plan of care, and supporting documentation. The request for prior authorization shall include all items previously identified as required treatment plan information and shall further include: any planned surgical interventions and projected time frame; information regarding caregiver's desire to become involved in the member's care, to adhere to program objectives, to work toward treatment plan goals, and to work toward maximum independence; and identify the types and service delivery levels of all other services

to the member whether or not the services are reimbursable by Medicaid. Providers shall indicate the expected number of private duty nursing RN hours, private duty nursing LPN hours, or home health aide hours per day, the number of days per week, and the number of weeks or months of service per discipline. If the member is currently hospitalized, the projected date of discharge shall be included.

Prior authorization approvals shall not be granted for treatment plans that exceed 16 hours of home health agency services per day. (Cross-reference 78.28(9))

78.9(11) Vaccines. In order to be paid for the administration of a vaccine covered under the Vaccines for Children (VFC) Program, a home health agency must enroll in the VFC program. Payment for the vaccine will be approved only if the VFC program stock has been depleted.

This rule is intended to implement Iowa Code section 249A.4.

[ARC 7548B, IAB 2/11/09, effective 4/1/09; ARC 9315B, IAB 12/29/10, effective 2/2/11; ARC 0065C, IAB 4/4/12, effective 6/1/12]

441—78.10(249A) Durable medical equipment (DME), prosthetic devices and medical supplies.

78.10(1) General payment requirements. Payment will be made for items of DME, prosthetic devices and medical supplies, subject to the following general requirements and the requirements of subrule 78.10(2), 78.10(3), or 78.10(4), as applicable:

a. DME, prosthetic devices, and medical supplies must be required by the member because of the member's medical condition.

b. The item shall be necessary and reasonable either for the treatment of an illness or injury, or to improve the functioning of a malformed body part. Determination will be made by the Iowa Medicaid enterprise medical services unit.

(1) An item is necessary when it can be expected to make a meaningful contribution to the treatment of a specific illness or injury or to the improvement in function of a malformed body part.

(2) Although an item may be necessary, it must also be a reasonable expenditure for the Medicaid program. The following considerations enter into the determination of reasonableness: Whether the expense of the item to the program would be clearly disproportionate to the therapeutic benefits which could ordinarily be derived from use of the item; whether the item would be substantially more costly than a medically appropriate and realistically feasible alternative pattern of care; and whether the item serves essentially the same purpose as an item already available to the beneficiary.

c. A physician's (doctor of medicine, osteopathy, or podiatry), physician assistant's, or advanced registered nurse practitioner's prescription is required to establish medical necessity. The prescription shall state the member's name, diagnosis, prognosis, item(s) to be dispensed, quantity, and length of time the item is to be required and shall include the signature of the prescriber and the date of signature.

For items requiring prior authorization, a request shall include a physician's, physician assistant's, or advanced registered nurse practitioner's written order or prescription and sufficient medical documentation to permit an independent conclusion that the requirements for the equipment or device are met and the item is medically necessary and reasonable. A request for prior authorization is made on Form 470-0829, Request for Prior Authorization. See rule 441—78.28(249A) for prior authorization requirements.

d. Nonmedical items will not be covered. These include but are not limited to:

- (1) Physical fitness equipment, e.g., an exercycle, weights.
- (2) First-aid or precautionary-type equipment, e.g., preset portable oxygen units.
- (3) Self-help devices, e.g., safety grab bars, raised toilet seats.
- (4) Training equipment, e.g., speech teaching machines, braille training texts.
- (5) Equipment used for environmental control or to enhance the environmental setting, e.g., room heaters, air conditioners, humidifiers, dehumidifiers, and electric air cleaners.
- (6) Equipment which basically serves comfort or convenience functions or is primarily for the convenience of a person caring for the member, e.g., elevators, stairway elevators and posture chairs.

e. The amount payable is based on the least expensive item which meets the member's medical needs. Payment will not be approved for items that serve duplicate functions. EXCEPTION: A second ventilator for which prior authorization has been granted. See 78.10(5) "k" for prior authorization requirements.

f. Consideration will be given to rental or purchase based on the price of the item and the length of time it would be required. The decision on rental or purchase shall be made by the Iowa Medicaid enterprise and be based on the most reasonable method to provide the equipment.

(1) The provider shall monitor rental payments up to 100 percent of the purchase price. At the point that total rent paid equals 100 percent of the purchase allowance, the member will be considered to own the item and no further rental payments will be made to the provider.

(2) Payment may be made for the purchase of an item even though rental payments may have been made for prior months. The rental of the equipment may be necessary for a period of time to establish that it will meet the identified need before the purchase of the equipment. When a decision is made to purchase after renting an item, all of the rental payments will be applied to the purchase allowance.

(3) EXCEPTION: Ventilators and oxygen systems shall be maintained on a rental basis for the duration of use.

(4) A deposit shall not be charged by a provider to a Medicaid member or any other person on behalf of a Medicaid member for rental of medical equipment.

g. Payment may be made for necessary repair, maintenance, and supplies for member-owned equipment. No payment may be made for repairs, maintenance, or supplies when the member is renting the item.

h. Replacement of member-owned equipment is covered in cases of loss or irreparable damage or when required because of a change in the member's condition.

i. No allowance will be made for delivery, freight, postage, or other provider operating expenses for DME, prosthetic devices or medical supplies.

j. Reimbursement over the established fee schedule amount is allowed when prior authorization has been obtained. See 78.10(5) "n" for prior authorization requirements.

78.10(2) Durable medical equipment. DME is equipment that can withstand repeated use, is primarily and customarily used to serve a medical purpose, is generally not useful to a person in the absence of an illness or injury, and is appropriate for use in the home.

a. Durable medical equipment provided in a hospital, nursing facility, or intermediate care facility for persons with an intellectual disability is not separately payable.

EXCEPTIONS:

(1) Oxygen services in a nursing facility or an intermediate care facility for persons with an intellectual disability when all of the following requirements and conditions have been met:

1. A Certificate of Medical Necessity for Oxygen, Form CMS-484, or a reasonable facsimile is completed by a physician, physician assistant, or advanced registered nurse practitioner and qualifies the member in accordance with Medicare criteria.

2. Additional documentation shows that the member requires oxygen for 12 hours or more per day for at least 30 days.

3. Oxygen logs must be maintained by the provider. The time between any reading shall not exceed more than 45 days. The documentation maintained in the provider record must contain the following:

- The initial, periodic and ending reading on the time meter clock on each oxygen system, and
 - The dates of each initial, periodic and ending reading, and
 - Evidence of ongoing need for oxygen services.
4. The maximum Medicaid payment shall be based on the least costly method of oxygen delivery.
5. Oxygen prescribed "PRN" or "as necessary" is not payable.

6. Medicaid payment shall be made for the rental of equipment only. All accessories and disposable supplies related to the oxygen delivery system and costs for servicing and repair of equipment are included in the Medicaid payment and shall not be separately payable.

7. Payment is not allowed for oxygen services that are not documented according to the department of inspections and appeals requirements at 481—subrule 58.21(8).

(2) Speech generating devices for which prior authorization has been obtained. See 78.10(5) "f" for prior authorization requirements.

(3) Wheelchairs for members in an intermediate care facility for persons with an intellectual disability.

(4) Medicaid will provide separate payment for customized wheelchairs for members who are residents of nursing facilities, subject to the following:

1. The member's condition must necessitate regular use of a wheelchair on a long-term basis to enable independent mobility within the facility.

2. The member must require a wheelchair that is designed, assembled, modified, or constructed for the specific individual, in whole or in part, based on the individual's condition, measurements, and needs.

3. Prior authorization pursuant to rule 441—79.8(249A) is required.

b. The types of durable medical equipment covered through the Medicaid program include, but are not limited to:

Automated medication dispenser. See 78.10(5) "d" for prior authorization requirements.

Bathtub/shower chair, bench. See 78.10(5) "g" and "j" for prior authorization requirements.

Commode, shower commode chair. See 78.10(5) "j" for prior authorization requirements.

Decubitus equipment.

Dialysis equipment.

Diaphragm (contraceptive device).

Enclosed bed. See 78.10(5) "a" for prior authorization requirements.

Enuresis alarm system (bed-wetting alarm device) for members five years of age or older.

Heat/cold application device.

Hospital bed and accessories.

Inhalation equipment. See 78.10(5) "c" for prior authorization requirements.

Insulin infusion pump. See 78.10(5) "b" and 78.10(5) "e" for prior authorization requirements.

Lymphedema pump.

Mobility device and accessories. See 78.10(5) "i" for prior authorization requirements.

Neuromuscular stimulator.

Oximeter.

Oxygen, subject to the limitations in 78.10(2) "a" and 78.10(2) "c."

Patient lift. See 78.10(5) "h" for prior authorization requirements.

Phototherapy bilirubin light.

Protective helmet.

Seat lift chair.

Speech generating device. See 78.10(5) "f" for prior authorization requirements.

Traction equipment.

Ventilator.

c. Coverage of home oxygen equipment and oxygen will be considered reasonable and necessary for members in accordance with Medicare criteria and as shown by supporting medical documentation. The physician, physician assistant, or advanced registered nurse practitioner shall document that other forms of treatment are contraindicated or have been tried and have not been successful and that oxygen therapy is required. EXCEPTION: Home oxygen equipment and oxygen are covered for children through three years of age when prescribed by a physician, physician assistant or advanced registered nurse practitioner. A pulse oximeter reading must be obtained yearly and documented in the provider and physician record.

(1) To identify the medical necessity for oxygen therapy, a Certificate of Medical Necessity for Oxygen, Form CMS-484, or a reasonable facsimile completed by a physician, physician assistant, or advanced registered nurse practitioner, shall qualify the member in accordance with Medicare criteria.

(2) If the member's condition or need for oxygen services changes, the attending physician, physician assistant, or advanced registered nurse practitioner must adjust the documentation accordingly.

(3) A second oxygen system is not covered by Medicaid when used as a backup for oxygen concentrators or as a standby in case of emergency. Members may be provided with a portable oxygen system to complement a stationary oxygen system, or to be used by itself, with documentation from

the physician, physician assistant, or advanced registered nurse practitioner of the specific activities for which portable oxygen is medically necessary.

(4) Payment for oxygen systems shall be made only on a rental basis for the duration of use.

(5) All accessories, disposable supplies, servicing, and repairing of oxygen systems are included in the monthly Medicaid payment for oxygen systems.

(6) Oxygen prescribed “PRN” or “as necessary” is not allowed.

78.10(3) *Prosthetic devices.* Prosthetic devices mean replacement, corrective, or supportive devices prescribed by a physician (doctor of medicine, osteopathy or podiatry), physician assistant, or advanced registered nurse practitioner within the scope of practice as defined by state law to artificially replace a missing portion of the body, prevent or correct a physical deformity or malfunction, or support a weak or deformed portion of the body. This does not require a determination that there is no possibility that the member’s condition may improve sometime in the future.

a. Prosthetic devices are not covered when dispensed to a member prior to the time the member undergoes a procedure which will make necessary the use of the device.

b. The types of prosthetic devices covered through the Medicaid program include, but are not limited to:

(1) Artificial eyes.

(2) Artificial limbs.

(3) Enteral delivery supplies and products. See 78.10(5) “*l*” for prior authorization requirements.

(4) Hearing aids. See rule 441—78.14(249A).

(5) Orthotic devices. See 78.10(3) “*c*” for limitations on coverage of cranial orthotic devices.

(6) Ostomy appliances.

(7) Parenteral delivery supplies and products. Daily parenteral nutrition therapy is considered necessary and reasonable for a member with severe pathology of the alimentary tract that does not allow absorption of sufficient nutrients to maintain weight and strength commensurate with the member’s general condition.

(8) Prosthetic shoes, orthopedic shoes. See rule 441—78.15(249A).

(9) Tracheotomy tubes.

(10) Vibrotactile aids. Vibrotactile aids are payable only once in a four-year period unless the original aid is broken beyond repair or lost. (Cross-reference 78.28(4))

c. Cranial orthotic device. Payment shall be approved for cranial orthotic devices when the device is medically necessary for the postsurgical treatment of synostotic plagiocephaly. Payment shall also be approved when there is documentation supporting moderate to severe nonsynostotic positional plagiocephaly and either:

(1) The member is 12 weeks of age but younger than 36 weeks of age and has failed to respond to a two-month trial of repositioning therapy; or

(2) The member is 36 weeks of age but younger than 108 weeks of age and there is documentation of either of the following conditions:

1. Cephalic index at least two standard deviations above the mean for the member’s gender and age; or

2. Asymmetry of 12 millimeters or more in the cranial vault, skull base, or orbitotragial depth.

78.10(4) *Medical supplies.* Medical supplies are nondurable items consumed in the process of giving medical care, for example, nebulizers, gauze, bandages, sterile pads, adhesive tape, and sterile absorbent cotton. Medical supplies are payable for a specific medicinal purpose. This does not include food or drugs. However, active pharmaceutical ingredients and excipients that are identified as preferred on the preferred drug list published by the department pursuant to Iowa Code section 249A.20A are covered. Medical supplies shall not be dispensed at any one time in quantities exceeding a 31-day supply for active pharmaceutical ingredients and excipients or a three-month supply for all other items. After the initial dispensing of medical supplies, the provider must document a refill request from the Medicaid member or the member’s caregiver for each refill.

a. The types of medical supplies and supplies necessary for the effective use of a payable item covered through the Medicaid program include, but are not limited to:

Active pharmaceutical ingredients and excipients identified as preferred on the preferred drug list published pursuant to Iowa Code section 249A.20A.

Catheter (indwelling Foley).

Colostomy and ileostomy appliances.

Colostomy and ileostomy care dressings, liquid adhesive, and adhesive tape.

Diabetic supplies (including but not limited to blood glucose test strips, lancing devices, lancets, needles, syringes, and diabetic urine test supplies). See 78.10(5) “e” for prior authorization requirements.

Dialysis supplies.

Disposable catheterization trays or sets (sterile).

Disposable irrigation trays or sets (sterile).

Disposable saline enemas (e.g., sodium phosphate type).

Dressings.

Elastic antiembolism support stocking.

Enema.

Hearing aid batteries.

Incontinence products (for members three years of age and older).

Oral nutritional products. See 78.10(5) “m” for prior authorization requirements.

Ostomy appliances and supplies.

Respirator supplies.

Shoes, diabetic.

Surgical supplies.

Urinary collection supplies.

b. Only the following types of medical supplies will be approved for payment for members receiving care in a nursing facility or an intermediate care facility for persons with an intellectual disability when prescribed by the physician, physician assistant, or advanced registered nurse practitioner:

Catheter (indwelling Foley).

Diabetic supplies (including but not limited to lancing devices, lancets, needles and syringes, blood glucose test strips, and diabetic urine test supplies).

Disposable catheterization trays or sets (sterile).

Disposable irrigation trays or sets (sterile).

Disposable saline enemas (e.g., sodium phosphate type).

Ostomy appliances and supplies.

Shoes, diabetic.

78.10(5) Prior authorization requirements. Prior authorization pursuant to rule 441—79.8(249A) is required for the following medical equipment and supplies (Cross-reference 78.28(1)):

a. Enclosed beds. Payment for an enclosed bed shall be approved when prescribed for a member who meets all of the following conditions:

(1) The member has a diagnosis-related cognitive or communication impairment that results in risk to safety.

(2) The member’s mobility puts the member at risk for injury.

b. External insulin infusion pumps. Payment will be approved according to Medicare coverage criteria.

c. Vest airway clearance systems. Payment will be approved for a vest airway clearance system when prescribed by a pulmonologist for a member with a diagnosis of a lung disorder if all of the following conditions are met:

(1) Pulmonary function tests for the 12 months before the initiation of the vest demonstrate an overall significant decrease in lung function.

(2) The member resides in an independent living situation or has a medical condition that precludes the caregiver from administering traditional chest physiotherapy.

(3) Treatment by flutter device failed or is contraindicated.

(4) Treatment by intrapulmonary percussive ventilation failed or is contraindicated.

(5) All other less costly alternatives have been tried.

d. Automated medication dispenser. Payment will be approved for an automated medication dispenser when prescribed for a member who meets all of the following conditions:

(1) The member has a diagnosis indicative of cognitive impairment or age-related factors that affect the member's ability to remember to take medications.

(2) The member is on two or more medications prescribed to be administered more than one time per day.

(3) The availability of a caregiver to administer the medications or perform setup is limited or nonexistent.

(4) Less costly alternatives, such as medisets or telephone reminders, have failed.

e. Diabetic equipment and supplies. If the department has a current agreement for a rebate with at least one manufacturer of a particular category of diabetic equipment or supplies (by healthcare common procedure coding system (HCPCS) code), prior authorization is required for any equipment or supplies in that category produced by a manufacturer that does not have a current agreement to provide a rebate to the department (other than supplies for members receiving care in a nursing facility or an intermediate care facility for persons with an intellectual disability). Prior approval shall be granted when the member's medical condition necessitates use of equipment or supplies produced by a manufacturer that does not have a current rebate agreement with the department.

f. Speech generating device. Payment shall be approved according to Medicare coverage criteria. Form 470-2145, Speech Generating Device System Selection, completed by a speech-language pathologist and a physician's, physician assistant's, or advanced registered nurse practitioner's prescription for a particular device shall be submitted with the request for prior authorization. In addition, documentation from a speech-language pathologist must include information on the member's educational ability and needs, vocational potential, anticipated duration of need, prognosis regarding oral communication skills, prognosis with a particular device, and recommendations. A minimum one-month trial period is required for all devices. The Iowa Medicaid enterprise consultant with expertise in speech-language pathology will evaluate each prior authorization request and make recommendations to the department.

g. Bathtub/shower chair, bench. Payment shall be approved for specialized bath equipment for members whose medical condition necessitates additional body support while bathing.

h. Patient lift, nonstandard. Payment shall be approved for a nonstandard lift, such as a portable, ceiling or electric lifter, when the member meets the Medicare criteria for a patient lift and a standard lifter (Hoyer type) will not work.

i. Power wheelchair attendant control. Payment shall be approved when the member has a power wheelchair and:

(1) Has a sip 'n puff attachment, or

(2) The medical documentation demonstrates the member's difficulty operating the wheelchair in tight space, or

(3) The medical documentation demonstrates the member becomes fatigued.

j. Shower commode chairs. Prior authorization shall be granted when documentation from a physician, physician assistant, advanced registered nurse practitioner, physical therapist or occupational therapist indicates that the member:

(1) Is unable to stand for the duration of a shower or is unable to get in or out of a bathtub, and

(2) Needs upper body support while sitting, and

(3) Needs to be tilted back for safety or pressure relief, if a tilt-in-space chair is requested.

k. Ventilator, secondary. Payment shall be approved according to the Medicare coverage criteria.

l. Enteral products and enteral delivery pumps and supplies. Payment shall be approved according to Medicare coverage criteria. EXCEPTION: The Medicare criteria for permanence is not required.

m. Oral nutritional products. Payment shall be approved when the member is not able to ingest or absorb sufficient nutrients from regular food due to a metabolic, digestive, or psychological disorder or pathology, to the extent that supplementation is necessary to provide 51 percent or more of the daily caloric intake, or when the use of oral nutritional products is otherwise determined medically necessary

in accordance with evidence-based guidelines for treatment of the member's condition. Nutritional products consumed orally are not covered for members in nursing facilities or intermediate care facilities for persons with an intellectual disability.

n. Reimbursement over the established Medicaid fee schedule amount. Payment shall be approved for bariatric equipment, pediatric equipment or other specialized medical equipment, supply, prosthetic or orthotic which:

(1) Meets the definition of a code in the current healthcare common procedure coding system (HCPCS), and

(2) Has an established Medicaid fee schedule amount that is inadequate to cover the provider's cost to obtain the equipment or supply.

o. Customized wheelchairs for members who are residents of nursing facilities, subject to the requirements of 78.10(2) "a"(4).

This rule is intended to implement Iowa Code sections 249A.3, 249A.4 and 249A.12.

[ARC 7548B, IAB 2/11/09, effective 4/1/09; ARC 8344B, IAB 12/2/09, effective 12/1/09; ARC 8643B, IAB 4/7/10, effective 3/11/10; ARC 8714B, IAB 5/5/10, effective 5/1/10; ARC 8993B, IAB 8/11/10, effective 10/1/10; ARC 9256B, IAB 12/1/10, effective 1/1/11; ARC 0632C, IAB 3/6/13, effective 5/1/13; ARC 0823C, IAB 7/10/13, effective 9/1/13; ARC 1151C, IAB 10/30/13, effective 1/1/14]

441—78.11(249A) Ambulance service. Payment will be approved for ambulance service if it is required by the recipient's condition and the recipient is transported to the nearest hospital with appropriate facilities or to one in the same locality, from one hospital to another, to the patient's home or to a nursing facility. Payment for ambulance service to the nearest hospital for outpatient service will be approved only for emergency treatment. Ambulance service must be medically necessary and not merely for the convenience of the patient.

78.11(1) Partial payment may be made when an individual is transported beyond the destinations specified, and is limited to the amount that would have been paid had the individual been transported to the nearest institution with appropriate facilities. When transportation is to the patient's home, partial payment is limited to the amount that would have been paid from the nearest institution with appropriate facilities. When a recipient who is a resident of a nursing care facility is hospitalized and later discharged from the hospital, payment will be made for the trip to the nursing care facility where the recipient resides even though it may not in fact be the nearest nursing care facility.

78.11(2) The Iowa Medicaid enterprise medical services unit shall determine that the ambulance transportation was medically necessary and that the condition of the patient precluded any other method of transportation. Payment can be made without the physician's confirmation when:

a. The individual is admitted as a hospital inpatient or in an emergency situation.

b. Previous information on file relating to the patient's condition clearly indicates ambulance service was necessary.

78.11(3) When a patient is transferred from one nursing home to another because of the closing of a facility or from a nursing home to a custodial home because the recipient no longer requires nursing care, the conditions of medical necessity and the distance requirements shall not be applicable. Approval for transfer shall be made by the local office of the department of human services prior to the transfer. When such a transfer is made, the following rate schedule shall apply:

One patient - normal allowance

Two patients - 3/4 normal allowance per patient

Three patients - 2/3 normal allowance per patient

Four patients - 5/8 normal allowance per patient

78.11(4) Transportation of hospital inpatients. When an ambulance service provides transport of a hospital inpatient to a provider and returns the recipient to the same hospital (the recipient continuing to be an inpatient of the hospital), the ambulance service shall bill the hospital for reimbursement as the hospital's DRG reimbursement system includes all costs associated with providing inpatient services as stated in 441—paragraph 79.1(5) "j."

78.11(5) In the event that more than one ambulance service is called to provide ground ambulance transport, payment shall be made only to one ambulance company. When a paramedic from one

ambulance service joins a ground ambulance company already in transport, coverage is not available for the services and supplies provided by the paramedic.

This rule is intended to implement Iowa Code section 249A.4.

441—78.12(249A) Behavioral health intervention. Payment will be made for behavioral health intervention services not otherwise covered under this chapter that are designed to minimize or, if possible, eliminate the symptoms or causes of an Axis I psychological disorder, subject to the limitations in this rule.

78.12(1) Definitions.

“Axis I disorder” means a diagnosed mental disorder, except for personality disorders and mental retardation, as set forth in the “Diagnostic and Statistical Manual IV-TR,” Fourth Edition.

“Behavioral health intervention” means skill-building services that focus on:

1. Addressing the mental and functional disabilities that negatively affect a member’s integration and stability in the community and quality of life;
2. Improving a member’s health and well-being related to the member’s Axis I disorder by reducing or managing the symptoms or behaviors that prevent the member from functioning at the member’s best possible functional level; and
3. Promoting a member’s mental health recovery and resilience through increasing the member’s ability to manage symptoms.

“Licensed practitioner of the healing arts” or *“LPHA,”* as used in this rule, means a practitioner such as a physician (M.D. or D.O.), an advanced registered nurse practitioner (ARNP), a psychologist, a social worker (LMSW or LISW), a marital and family therapist (LMFT), or a mental health counselor (LMHC) who:

1. Is licensed by the applicable state authority for that profession;
2. Is enrolled in the Iowa Plan for Behavioral Health (Iowa Plan) pursuant to 441—Chapter 88, Division IV; and
3. Is qualified to provide clinical assessment services (Current Procedural Terminology code 90801) under the Iowa Plan pursuant to 441—Chapter 88, Division IV.

78.12(2) Covered services.

a. Service setting.

(1) Community-based behavioral health intervention is available to a member living in a community-based environment. Services have a primary goal of assisting the member and the member’s family to learn age-appropriate skills to manage behavior and regain or retain self-control. Depending on the member’s age and diagnosis, specific services offered may include:

1. Behavior intervention,
2. Crisis intervention,
3. Skill training and development, and
4. Family training.

(2) Residential behavioral health intervention is available to members eligible for foster group care payment pursuant to 441—subrule 156.20(1). Services have the primary goal of assisting the member to prepare to transition to the community through learning age-appropriate skills to manage behavior and regain or retain self-control. Specific services offered include:

1. Behavior intervention,
2. Crisis intervention, and
3. Family training.

(3) Behavioral health intervention is not covered for members who are in an acute care or psychiatric hospital, a long-term care facility, or a psychiatric medical institution for children.

b. Crisis intervention. Crisis intervention services shall provide a focused intervention and rapid stabilization of acute symptoms of mental illness or emotional distress. The intervention shall be designed to de-escalate situations in which a risk to self, others, or property exists.

(1) Services shall assist a member to regain self-control and reestablish effective management of behavioral symptoms associated with a psychological disorder in an age-appropriate manner.

(2) Crisis intervention is covered only for Medicaid members who are aged 20 or under and shall be provided as outlined in a written treatment plan.

(3) Crisis intervention services do not include control room or other restraint activities.

c. Behavior intervention. Behavior intervention includes services designed to modify the psychological, behavioral, emotional, cognitive, and social factors affecting a member's functioning.

(1) Interventions may address the following skills for effective functioning with family, peers, and community in an age-appropriate manner:

1. Cognitive flexibility skills,
2. Communication skills,
3. Conflict resolution skills,
4. Emotional regulation skills,
5. Executive skills,
6. Interpersonal relationship skills,
7. Problem-solving skills, and
8. Social skills.

(2) Behavior intervention shall be provided in a location appropriate for skill identification, teaching and development. Intervention may be provided in an individual, family, or group format as appropriate to meet the member's needs.

(3) Behavior intervention is covered only for Medicaid members aged 20 or under.

(4) Covered services include only direct teaching or development of skills and not general recreation, non-skill-based activities, mentoring, or interruption of school.

d. Family training. Family training is covered only for Medicaid members aged 20 or under.

(1) Family training services shall:

1. Enhance the family's ability to effectively interact with the child and support the child's functioning in the home and community, and
2. Teach parents to identify and implement strategies to reduce target behaviors and reinforce the appropriate skills.

(2) Training provided must:

1. Be for the direct benefit of the member, and
2. Be based on a curriculum with a training manual.

e. Skill training and development. Skill training and development services are covered for Medicaid members aged 18 or over.

(1) Skill training and development shall consist of interventions to:

1. Enhance a member's independent living, social, and communication skills;
2. Minimize or eliminate psychological barriers to a member's ability to effectively manage symptoms associated with a psychological disorder; and
3. Maximize a member's ability to live and participate in the community.

(2) Interventions may include training in the following skills for effective functioning with family, peers, and community:

1. Communication skills,
2. Conflict resolution skills,
3. Daily living skills,
4. Employment-related skills,
5. Interpersonal relationship skills,
6. Problem-solving skills, and
7. Social skills.

78.12(3) Excluded services.

a. Services that are habilitative in nature are not covered under behavioral health intervention. For purposes of this subrule, "habilitative services" means services that are designed to assist individuals in acquiring skills that they never had, as well as associated training to acquire self-help, socialization, and adaptive skills necessary to reside successfully in a home or community setting.

b. Respite, day care, education, and recreation services are not covered under behavioral health intervention.

78.12(4) Coverage requirements. Medicaid covers behavioral health intervention only when the following conditions are met:

a. A licensed practitioner of the healing arts acting within the practitioner's scope of practice under state law has diagnosed the member with a psychological disorder.

b. The licensed practitioner of the healing arts has recommended the behavioral health intervention as part of a plan of treatment designed to treat the member's psychological disorder. The plan of treatment shall be comprehensive in nature and shall detail all behavioral health services that the member may require, not only services included under behavioral health intervention.

(1) The member's need for services must meet specific individual goals that are focused to address:

1. Risk of harm to self or others,
2. Behavioral support in the community,
3. Specific skills impaired due to the member's mental illness, and
4. Needs of children at risk of out-of-home placement due to mental health needs or the transition back to the community or home following an out-of-home placement.

(2) Diagnosis and treatment plan development provided in connection with this rule for members enrolled in the Iowa Plan are covered services under the Iowa Plan pursuant to 441—Chapter 88, Division IV.

c. For a member under the age of 21, the licensed practitioner of the healing arts:

(1) Has, in cooperation with the managed care contractor, selected a standardized assessment instrument appropriate for baseline measurement of the member's current skill level in managing mental health needs;

(2) Has completed an initial formal assessment of the member using the instrument selected; and

(3) Completes a formal assessment every six months thereafter if continued services are ordered.

d. The behavioral health intervention provider has prepared a written services implementation plan that meets the requirements of subrule 78.12(5).

78.12(5) Approval of plan. The behavioral health intervention provider shall contact the Iowa Plan provider for authorization of the services.

a. *Initial plan.* The initial services implementation plan must meet all of the following criteria:

(1) The plan conforms to the medical necessity requirements in subrule 78.12(6);

(2) The plan is consistent with the written diagnosis and treatment recommendations made by the licensed practitioner of the healing arts;

(3) The plan is sufficient in amount, duration, and scope to reasonably achieve its purpose;

(4) The provider meets the requirements of rule 441—77.12(249A); and

(5) The plan does not exceed six months' duration.

b. *Subsequent plans.* The Iowa Plan contractor may approve a subsequent services implementation plan according to the conditions in paragraph 78.12(5) "a" if the services are recommended by a licensed practitioner of the healing arts who has:

(1) Reexamined the member;

(2) Reviewed the original diagnosis and treatment plan; and

(3) Evaluated the member's progress, including a formal assessment as required by 78.12(4) "c" (3).

78.12(6) Medical necessity. Nothing in this rule shall be deemed to exempt coverage of behavioral health intervention from the requirement that services be medically necessary. For purposes of behavioral health intervention, "medically necessary" means that the service is:

a. Consistent with the diagnosis and treatment of the member's condition and specific to a daily impairment caused by an Axis I disorder;

b. Required to meet the medical needs of the member and is needed for reasons other than the convenience of the member or the member's caregiver;

c. The least costly type of service that can reasonably meet the medical needs of the member; and

d. In accordance with the standards of evidence-based medical practice. The standards of practice for each field of medical and remedial care covered by the Iowa Medicaid program are those standards of practice identified by:

- (1) Knowledgeable Iowa clinicians practicing or teaching in the field; and
- (2) The professional literature regarding evidence-based practices in the field.

This rule is intended to implement Iowa Code section 249A.4 and 2010 Iowa Acts, chapter 1192, section 31.

[ARC 8504B, IAB 2/10/10, effective 3/22/10; ARC 9487B, IAB 5/4/11, effective 7/1/11]

441—78.13(249A) Nonemergency medical transportation. The department makes available nonemergency medical transportation through a transportation brokerage. Medicaid members who are eligible for full Medicaid benefits and need transportation services so that they can receive Medicaid-covered services from providers enrolled with the Iowa Medicaid program may obtain transportation services consistent with this rule.

78.13(1) Covered services. Nonemergency medical transportation services available are limited to:

a. The most economical transportation appropriate to the needs of the member, provided to members eligible for nonemergency transportation when those members need transportation to providers enrolled in the Iowa Medicaid program for the receipt of goods or services covered by the Iowa Medicaid program. Consistent with the member's needs and subject to the limitations and restrictions set forth in this rule, subject to the advance approval of the broker, such transportation may include:

- (1) Mileage reimbursement to the member, if the member is the driver.
- (2) Mileage reimbursement to a volunteer or other responsible person, if the volunteer or other responsible person is the driver.
- (3) Taxi service.
- (4) Public transportation when public transportation is reasonably available and the member's condition does not preclude its use.
- (5) Wheelchair and stretcher vans.
- (6) Airfare costs when the most appropriate mode of transport is by air, based on the member's medical condition.

b. Reimbursement for costs of the member's meals necessary during periods of transportation and medical treatment.

c. Reimbursement of lodging expenses incurred by the member during periods of transportation and medical treatment.

d. Reimbursement of car rental costs incurred by the member during periods of transportation and medical treatment.

e. Reimbursement of a medically necessary escort's travel expenses when an escort is required because of the member's needs.

78.13(2) Exclusions. Nonemergency medical transportation is not available through the Iowa Medicaid program for:

- a. Transportation to obtain services not covered by Iowa Medicaid;
- b. Transportation to providers that are not enrolled in Iowa Medicaid;
- c. Transportation for members residing in nursing facilities or ICF/ID facilities when such facilities provide the transportation (i.e., within 30 miles, one way, of the facility);
- d. Transportation of family members to visit or participate in therapy when the member is hospitalized or institutionalized;
- e. Transportation to durable medical equipment providers when such providers offer a delivery service that can be accessed at no cost to the member, unless the equipment requires a fitting that cannot be provided without transporting the member;
- f. Reimbursement to HCBS and Medicaid providers for transportation provided as part of other covered services, such as personal care, home health, and supported community living services;

g. Transportation to a pharmacy that provides a free delivery service, with the exception of new prescription fills that are otherwise not available to the patient in the absence of nonemergency medical transportation services; and

h. Emergency transportation.

78.13(3) Conditions and limitations on covered services. Nonemergency medical transportation services are subject to the following limitations and conditions:

a. *Member request.* When a member needs nonemergency transportation to receive medical care provided by the Iowa Medicaid program, the member must contact the broker with as much advance notice as possible, but not more than 30 days' advance notice.

(1) Generally, the member must contact the broker at least two business days in advance of the member's appointment to schedule the transportation. For purposes of calculating the two-business-day notice obligation, the advance notice includes the day of the medical appointment but not the day of the telephone call.

(2) If the member's nonemergency transportation needs make the provision of two business days' notice impossible because of the member's urgent transportation need, the member must provide as much advance notice as is possible before the transportation need so that the broker can appropriately schedule the most economical form of transportation for the member. Urgent transportation needs are limited to unscheduled episodic situations in which there is no immediate threat to life or limb but which require that the broker schedule transportation with less than two business days' notice. Examples of urgent trips include, but are not limited to:

1. Postsurgical or medical follow-up care specified by a health care provider;
2. Unexpected preoperative appointments;
3. Hospital discharges;
4. Appointments for new medical conditions or tests; and
5. Dialysis.

b. *No free transportation alternatives available.* Member transportation through the nonemergency medical transportation broker is not available to the member when the member is capable of securing the member's own transportation at no cost to the member (e.g., free-gas voucher programs).

c. *No member transportation alternatives available.* Members who have their own transportation available to them are required to use their own vehicle and seek mileage reimbursement. For purposes of determining whether or not the member has the member's own transportation that is available to the member, the broker shall take into consideration:

- (1) Whether the member owns a vehicle;
- (2) Whether a member-owned vehicle is in working mechanical order and is licensed;
- (3) Whether the member has a valid driver's license and auto insurance;
- (4) Whether the member is unable to drive because of age, physical condition, cognitive impairment, or developmental limitations; and
- (5) Whether friends or family are available to transport the member to the member's medical appointment and receive mileage reimbursement.

d. *Limitations on reimbursement for meals.* Reimbursement for costs of members' meals necessary during periods of transportation and medical treatment is limited to situations in which:

- (1) The transportation being provided spans the entire meal period;
- (2) The one-way distance to or from the medical appointment is more than 50 miles;
- (3) The meal is necessary to satisfy the needs of the member or medically necessary escort; and
- (4) The meal reimbursement is limited to the subsistence allowance amounts applicable to state officers and state employees pursuant to Iowa Administrative Code rule 11—41.6(8A) and is supported by detailed receipts.

e. *Limitations on reimbursement for lodging expenses.* Reimbursement of lodging expenses incurred by members during periods of transportation and medical treatment is limited to reasonable reimbursement for expenses incurred by the member or the medically necessary escort, or both,

during a nonemergency trip provided by the broker when the one-way distance to or from the medical appointment is more than 50 miles, supported by detailed receipts, and required for treatment.

f. Closest medical provider. Nonemergency medical transportation will only be provided to members to the closest qualified and enrolled Medicaid provider unless:

(1) The difference between the closest qualified and enrolled Medicaid provider and the enrolled provider requested by the member is less than 10 miles one way; or

(2) The additional cost of transportation to the enrolled provider requested by the member is medically justified based on:

1. The member's previous relationship with the requested provider; or
2. The member's prior experience with the requested provider; or
3. The requested provider's special expertise or experience; or
4. A referral requiring the member to be seen by the requested provider.

g. Member scheduling obligations. Members who require a ride will need to schedule medical appointments on days the transportation provider sends a shuttle to facilitate the provision of the most economical nonemergency medical transportation available, subject to reasonable medical exceptions.

h. Abusive behavior. Members who are abusive or inappropriate may be restricted by the department to only receiving mileage reimbursement. Such restricted members will be responsible for finding their own way to their medical appointments.

78.13(4) Grievance procedure. The broker shall establish an internal grievance procedure for members and transportation providers.

a. Members may appeal to the department pursuant to 441—Chapter 7 as an “aggrieved person.”

b. Transportation providers.

(1) Consent for state fair hearing.

1. Transportation providers that are contracted with the broker and are in good standing with the broker may request a state fair hearing only for disputes regarding payment of claims, specifically, disputes concerning the denial of a claim or reduction in payment, and only when acting on behalf of the member.

2. The transportation provider requesting such a state fair hearing must have the prior, express, signed written consent of the member or the member's lawfully appointed guardian in order to request such a hearing. Notwithstanding any contrary provision in 441—Chapter 7, no state fair hearing will be granted unless the transportation provider submits a document providing such member approval with the request for a state fair hearing.

3. The document must specifically inform the member that protected health information (PHI) may be discussed at the hearing and may be made public in the course of the hearing and subsequent administrative and judicial proceedings. The document must contain language that indicates the knowledge of the potential for PHI to become public and that the member knowingly, voluntarily and intelligently consents to the network provider's bringing the state fair hearing on the member's behalf.

(2) For all transportation provider grievances not addressed by paragraph 78.13(4)“b,” the grievance process shall end with binding arbitration, with a designee of the Iowa Medicaid enterprise as arbitrator.

[ARC 8344B, IAB 12/2/09, effective 12/1/09; ARC 8643B, IAB 4/7/10, effective 3/11/10; ARC 8994B, IAB 8/11/10, effective 10/1/10; ARC 1264C, IAB 1/8/14, effective 3/1/14]

441—78.14(249A) Hearing aids. Payment shall be approved for a hearing aid and examinations subject to the following conditions:

78.14(1) Physician examination. The member shall have an examination by a physician to determine that the member has no condition which would contraindicate the use of a hearing aid. This report shall be documented in the patient record. The requirement for a physician evaluation shall be waived for members 18 years of age or older when the member has signed an informed consent statement acknowledging that the member:

a. Has been advised that it may be in the member's best health interest to receive a medical evaluation from a licensed physician before purchase of a hearing aid.

b. Does not wish to receive a medical evaluation prior to purchase of a hearing aid.

78.14(2) *Audiological testings.* A physician or an audiologist shall perform audiological testing as a part of making a determination that a member could benefit from the use of a hearing aid. The department shall cover vestibular testing performed by an audiologist only when prescribed by a physician.

78.14(3) *Hearing aid evaluation.* A physician or an audiologist shall perform a hearing aid evaluation to establish if a member could benefit from a hearing aid. When a hearing aid is recommended for a member, the physician or audiologist recommending the hearing aid shall see the member at least one time within 30 days after purchase of the hearing aid to determine that the aid is adequate.

78.14(4) *Hearing aid selection.* A physician or audiologist may recommend a specific brand or model appropriate to the member's condition. When a physician or an audiologist makes a general hearing aid recommendation, a hearing aid dispenser may perform the tests to determine the specific brand or model appropriate to the member's condition.

78.14(5) *Travel.* When a member is unable to travel to the physician or audiologist because of health reasons, the department shall make payment for travel to the member's place of residence or other suitable location. The department shall make payment to physicians as specified in 78.1(8) and payment to audiologists at the same rate it reimburses state employees for travel.

78.14(6) *Purchase of hearing aid.* The department shall pay for the type of hearing aid recommended when purchased from an eligible licensed hearing aid dispenser pursuant to rule 441—77.13(249A). The department shall pay for binaural amplification when:

- a. A child needs the aid for speech development,
- b. The aid is needed for educational or vocational purposes,
- c. The aid is for a blind member,
- d. The member's hearing loss has caused marked restriction of daily activities and constriction of interests resulting in seriously impaired ability to relate to other people, or
- e. Lack of binaural amplification poses a hazard to a member's safety.

78.14(7) *Payment for hearing aids.*

a. Payment for hearing aids shall be acquisition cost plus a dispensing fee covering the fitting and service for six months. The department shall make payment for routine service after the first six months. Dispensing fees and payment for routine service shall not exceed the fee schedule appropriate to the place of service. Shipping and handling charges are not allowed.

b. Payment for ear mold and batteries shall be at the current audiologist's fee schedule.

c. Payment for repairs shall be made to the dealer for repairs made by the dealer. Payment for in-house repairs shall be made at the current fee schedule. Payment shall also be made to the dealer for repairs when the hearing aid is repaired by the manufacturer or manufacturer's depot. Payment for out-of-house repairs shall be at the amount shown on the manufacturer's invoice. Payment shall be allowed for a service or handling charge when it is necessary for repairs to be performed by the manufacturer or manufacturer's depot and this charge is made to the general public.

d. Prior approval. When prior approval is required, Form 470-4767, Examiner Report of Need for a Hearing Aid, shall be submitted along with the forms required by 441—paragraph 79.8(1) "a."

(1) Payment for the replacement of a hearing aid less than four years old shall require prior approval except when the member is under 21 years of age. The department shall approve payment when the original hearing aid is lost or broken beyond repair or there is a significant change in the member's hearing that would require a different hearing aid. (Cross-reference 78.28(4) "a")

(2) Payment for a hearing aid costing more than \$650 shall require prior approval. The department shall approve payment for either of the following purposes (Cross-reference 78.28(4) "b"):

1. Educational purposes when the member is participating in primary or secondary education or in a postsecondary academic program leading to a degree and an in-office comparison of an analog aid and a digital aid matched (+/- 5dB) for gain and output shows a significant improvement in either speech recognition in quiet or speech recognition in noise or an in-office comparison of two aids, one of which is single channel, shows significantly improved audibility.

2. Vocational purposes when documentation submitted indicates the necessity, such as varying amounts of background noise in the work environment and a need to converse in order to do the job,

and an in-office comparison of an analog aid and a digital aid matched (+/- 5dB) for gain and output shows a significant improvement in either speech recognition in quiet or speech recognition in noise or an in-office comparison of two aids, one of which is single channel, shows significantly improved audibility.

This rule is intended to implement Iowa Code section 249A.4.
[ARC 8008B, IAB 7/29/09, effective 8/1/09]

441—78.15(249A) Orthopedic shoes. Payment shall be approved only for depth or custom-molded orthopedic shoes, inserts, and modifications, subject to the following definitions and conditions.

78.15(1) Definitions.

“Custom-molded shoe” means a shoe that:

1. Has been constructed over a cast or model of the recipient’s foot;
2. Is made of leather or another suitable material of equal quality;
3. Has inserts that can be removed, altered, or replaced according to the recipient’s conditions and needs; and
4. Has some form of closure.

“Depth shoe” means a shoe that:

1. Has a full length, heel-to-toe filler that when removed provides a minimum of 3/16 inch of additional depth used to accommodate custom-molded or customized inserts;
2. Is made from leather or another suitable material of equal quality;
3. Has some form of closure; and
4. Is available in full and half sizes with a minimum of three widths, so that the sole is graded to the size and width of the upper portions of the shoe according to the American Standard last sizing schedule or its equivalent.

“Insert” means a foot mold or orthosis constructed of more than one layer of a material that:

1. Is soft enough and firm enough to take and hold an impression during use, and
2. Is molded to the recipient’s foot or is made over a model of the foot.

78.15(2) Prescription. The recipient shall present to the provider a written prescription by a physician, a podiatrist, a physician assistant, or an advanced registered nurse practitioner that includes all of the following:

1. The date.
2. The patient’s diagnosis.
3. The reason orthopedic shoes are needed.
4. The probable duration of need.
5. A specific description of any required modification of the shoes.

78.15(3) Diagnosis. The recipient shall have a diagnosis of an orthopedic, neuromuscular, vascular, or insensate foot condition, supported by applicable codes from the current version of the International Classification of Diseases (ICD). A diagnosis of flat feet is not covered.

a. A recipient with diabetes must meet the Medicare criteria for therapeutic depth and custom-molded shoes.

b. Custom-molded shoes are covered only when the recipient has a foot deformity and the provider has documentation of all of the following:

- (1) The reasons the recipient cannot be fitted with a depth shoe.
- (2) Pain.
- (3) Tissue breakdown or a high probability of tissue breakdown.
- (4) Any limitation on walking.

78.15(4) Frequency. Only two pairs of orthopedic shoes are allowed per recipient in a 12-month period unless documentation of change in size or evidence of excessive wear is submitted. EXCEPTION: School-aged children under the age of 21 may obtain athletic shoes in addition to the two pairs of shoes in a 12-month period.

This rule is intended to implement Iowa Code section 249A.4.

441—78.16(249A) Community mental health centers. Payment will be approved for all reasonable and necessary services provided by a psychiatrist on the staff of a community mental health center. Payment will be approved for services provided by a clinical psychologist, social worker or psychiatric nurse on the staff of the center, subject to the following conditions:

78.16(1) Payment to a community mental health center will be approved for reasonable and necessary services provided to members by a psychiatrist, psychologist, social worker or psychiatric nurse on the staff of the center under the following conditions:

a. Services must be rendered under the supervision of a board-eligible or board-certified psychiatrist. All services must be performed under the supervision of a board-eligible or board-certified psychiatrist subject to the conditions set forth in 78.16(1) “*b*” with the following exceptions:

- (1) Services by staff psychiatrists, or
- (2) Services rendered by psychologists meeting the requirements of the National Register of Health Service Providers in Psychology, or
- (3) Services provided by a staff member listed in this subrule performing the preliminary diagnostic evaluation of a member for voluntary admission to one of the state mental health institutes.

b. Supervisory process.

(1) Each patient shall have an initial evaluation completed which shall include at least one personal evaluation interview with a mental health professional, as defined under Iowa Code section 228.1. If the evaluation interview results indicate a need for an interview with a board-eligible or board-certified psychiatrist, then such referral shall be made. This must be accomplished before submission of the first claim for services rendered to that patient.

(2) Ongoing review and assessment of patients’ treatment needs, treatment plans, and the appropriateness of services rendered shall be assured through the peer review process in effect for community mental health centers, as directed by 2002 Iowa Acts, chapter 1120, section 13.

(3) and (4) Rescinded IAB 2/5/03, effective 2/1/03.

78.16(2) The treatment plans for and services rendered to patients of the center shall be evaluated and revised as necessary and appropriate, consistent with the standards of the peer review process described in subparagraph 78.16(1) “*b*”(1).

78.16(3) The peer review process and related activities, as described under subparagraph 78.16(1) “*b*”(1), are not payable as separate services under the Medicaid program. The center shall maintain the results of and information related to the peer review process, and these records shall be subject to audit by the department of human services or department designees, as necessary and appropriate.

78.16(4) Clinical records of medical assistance patients shall be available to the carrier on request. All these records shall be held confidential.

78.16(5) At the time of application for participation in the program the center will be provided with a form on which to list its professional staff. The center shall report acquisitions or losses of professional staff to the carrier within ten days.

78.16(6) Payment to a community mental health center will be approved for day treatment services for persons aged 21 or over if the center is certified by the department for day treatment services, the services are provided on the premises of the community mental health center or satellite office of the community mental health center, and the services meet the standards outlined herein.

a. Community mental health centers providing day treatment services for persons aged 21 or over shall have available a written narrative providing the following day treatment information:

(1) Documented need for day treatment services for persons aged 21 and over in the area served by the program, including studies, needs assessments, and consultations with other health care professionals.

(2) Goals and objectives of the day treatment program for persons aged 21 and over that meet the day treatment program guidelines noted in 78.16(6) “*b*.”

(3) Organization and staffing including how the day treatment program for persons aged 21 and over fits with the rest of the community mental health center, the number of staff, staff credentials, and the staff’s relationship to the program, e.g., employee, contractual, or consultant.

(4) Policies and procedures for the program including admission criteria, patient assessment, treatment plan, discharge plan, postdischarge services, and the scope of services provided.

(5) Any accreditations or other types of approvals from national or state organizations.

(6) The physical facility and any equipment to be utilized.

b. Day treatment services for persons aged 21 and over shall be structured, long-term services designed to assist in restoring, maintaining or increasing levels of functioning, minimizing regression, and preventing hospitalization.

(1) Service components include training in independent functioning skills necessary for self-care, emotional stability and psychosocial interactions and training in medication management.

(2) Services are structured with an emphasis on program variation according to individual need.

(3) Services are provided for a period of three to five hours per day, three or four times per week.

c. Payment will be approved for day treatment services provided by or under the general supervision of a mental health professional as defined in rule 441—33.1(225C,230A). When services are provided by an employee or consultant of the community mental health center who is not a mental health professional, the employee or consultant shall be supervised by a mental health professional who gives professional direction and active guidance to the employee or consultant and who retains responsibility for consumer care. The supervision shall be timely, regular, and documented. The employee or consultant shall meet the following minimum requirements:

(1) Have a bachelor's degree in a human services related field from an accredited college or university; or

(2) Have an Iowa license to practice as a registered nurse with two years of experience in the delivery of nursing or human services.

d. Persons aged 18 through 20 with chronic mental illness as defined by rule 441—24.1(225C) can receive day treatment services under this subrule or subrule 78.16(7).

78.16(7) Payment to a community mental health center will be approved for day treatment services for persons aged 20 or under if the center is certified by the department for day treatment services and the services are provided on the premises of the community mental health center or satellite office of the community mental health center. Exception: Field trips away from the premises are a covered service when the trip is therapeutic and integrated into the day treatment program's description and milieu plan.

Day treatment coverage will be limited to a maximum of 15 hours per week. Day treatment services for persons aged 20 or under shall be outpatient services provided to persons who are not inpatients in a medical institution or residents of a group care facility licensed under 441—Chapter 114.

a. Program documentation. Community mental health centers providing day treatment services for persons aged 20 or under shall have available a written narrative which provides the following day treatment program information:

(1) Documented need for day treatment services for persons aged 20 or under in the area served by the program, including studies, needs assessments, and consultations with other health care professionals.

(2) Goals and objectives of the day treatment program for persons aged 20 or under that meet the guidelines noted in paragraphs “c” to “h” below.

(3) Organization and staffing including how the day treatment program for persons aged 20 or under fits with the rest of the community mental health center, the number of staff, staff credentials, and the staff's relationship to the program, e.g., employee, contractual, or consultant.

(4) Policies and procedures for the program including admission criteria, patient assessment, treatment plan, discharge plan, postdischarge services, and the scope of services provided.

(5) Any accreditations or other types of approvals from national or state organizations.

(6) The physical facility and any equipment to be utilized.

b. Program standards. Medicaid day treatment program services for persons aged 20 and under shall meet the following standards:

(1) Staffing shall:

1. Be sufficient to deliver program services and provide stable, consistent, and cohesive milieu with a staff-to-patient ratio of no less than one staff for each eight participants. Clinical, professional, and paraprofessional staff may be counted in determining the staff-to-patient ratio.

Professional or clinical staff are those staff who are either mental health professionals as defined in rule 441—33.1(225C,230A) or persons employed for the purpose of providing offered services under the supervision of a mental health professional. All other staff (administrative, adjunctive, support, nonclinical, clerical, and consulting staff or professional clinical staff) when engaged in administrative or clerical activities shall not be counted in determining the staff-to-patient ratio or in defining program staffing patterns. Educational staff may be counted in the staff-to-patient ratio.

2. Reflect how program continuity will be provided.
3. Reflect an interdisciplinary team of professionals and paraprofessionals.
4. Include a designated director who is a mental health professional as defined in rule 441—33.1(225C,230A). The director shall be responsible for direct supervision of the individual treatment plans for participants and the ongoing assessment of program effectiveness.

5. Be provided by or under the general supervision of a mental health professional as defined in rule 441—33.1(225C,230A). When services are provided by an employee or consultant of the community mental health center who is not a mental health professional, the employee or consultant shall be supervised by a mental health professional who gives direct professional direction and active guidance to the employee or consultant and who retains responsibility for consumer care. The supervision shall be timely, regular and documented. The employee or consultant shall have a bachelor's degree in a human services related field from an accredited college or university or have an Iowa license to practice as a registered nurse with two years of experience in the delivery of nursing or human services. Exception: Other certified or licensed staff, such as certified addiction counselors or certified occupational and recreational therapy assistants, are eligible to provide direct services under the general supervision of a mental health professional, but they shall not be included in the staff-to-patient ratio.

- (2) There shall be written policies and procedures addressing the following: admission criteria; patient assessment; patient evaluation; treatment plan; discharge plan; community linkage with other psychiatric, mental health, and human service providers; a process to review the quality of care being provided with a quarterly review of the effectiveness of the clinical program; postdischarge services; and the scope of services provided.

- (3) The program shall have hours of operation available for a minimum of three consecutive hours per day, three days or evenings per week.

- (4) The length of stay in a day treatment program for persons aged 20 or under shall not exceed 180 treatment days per episode of care, unless the rationale for a longer stay is documented in the patient's case record and treatment plan every 30 calendar days after the first 180 treatment days.

- (5) Programming shall meet the individual needs of the patient. A description of services provided for patients shall be documented along with a schedule of when service activities are available including the days and hours of program availability.

- (6) There shall be a written plan for accessing emergency services 24 hours a day, seven days a week.

- (7) The program shall maintain a community liaison with other psychiatric, mental health, and human service providers. Formal relationships shall exist with hospitals providing inpatient programs to facilitate referral, communication, and discharge planning. Relationships shall also exist with appropriate school districts and educational cooperatives. Relationships with other entities such as physicians, hospitals, private practitioners, halfway houses, the department, juvenile justice system, community support groups, and child advocacy groups are encouraged. The provider's program description will describe how community links will be established and maintained.

- (8) Psychotherapeutic treatment services and psychosocial rehabilitation services shall be available. A description of the services shall accompany the application for certification.

- (9) The program shall maintain a distinct clinical record for each patient admitted. Documentation, at a minimum, shall include: the specific services rendered, the date and actual time services were rendered, who rendered the services, the setting in which the services were rendered, the amount of time it took to deliver the services, the relationship of the services to the treatment regimen described in the plan of care, and updates describing the patient's progress.

c. *Program services.* Day treatment services for persons aged 20 or under shall be a time-limited, goal-oriented active treatment program that offers therapeutically intensive, coordinated, structured clinical services within a stable therapeutic milieu. Time-limited means that the patient is not expected to need services indefinitely or lifelong, and that the primary goal of the program is to improve the behavioral functioning or emotional adjustment of the patient in order that the service is no longer necessary. Day treatment services shall be provided within the least restrictive therapeutically appropriate context and shall be community-based and family focused. The overall expected outcome is clinically adaptive behavior on the part of the patient and the family.

At a minimum, day treatment services will be expected to improve the patient's condition, restore the condition to the level of functioning prior to onset of illness, control symptoms, or establish and maintain a functional level to avoid further deterioration or hospitalization. Services are expected to be age-appropriate forms of psychosocial rehabilitation activities, psychotherapeutic services, social skills training, or training in basic care activities to establish, retain or encourage age-appropriate or developmentally appropriate psychosocial, educational, and emotional adjustment.

Day treatment programs shall use an integrated, comprehensive and complementary schedule of therapeutic activities and shall have the capacity to treat a wide array of clinical conditions.

The following services shall be available as components of the day treatment program. These services are not separately billable to Medicaid, as day treatment reimbursement includes reimbursement for all day treatment components.

(1) Psychotherapeutic treatment services (examples would include individual, group, and family therapy).

(2) Psychosocial rehabilitation services. Active treatment examples include, but are not limited to, individual and group therapy, medication evaluation and management, expressive therapies, and theme groups such as communication skills, assertiveness training, other forms of community skills training, stress management, chemical dependency counseling, education, and prevention, symptom recognition and reduction, problem solving, relaxation techniques, and victimization (sexual, emotional, or physical abuse issues).

Other program components may be provided, such as personal hygiene, recreation, community awareness, arts and crafts, and social activities designed to improve interpersonal skills and family mental health. Although these other services may be provided, they are not the primary focus of treatment.

(3) Evaluation services to determine need for day treatment prior to program admission. For persons for whom clarification is needed to determine whether day treatment is an appropriate therapy approach, or for persons who do not clearly meet admission criteria, an evaluation service may be performed. Evaluation services shall be individual and family evaluation activities made available to courts, schools, other agencies, and individuals upon request, who assess, plan, and link individuals with appropriate services. This service must be completed by a mental health professional. An evaluation from another source performed within the previous 12 months or sooner if there has not been a change may be substituted. Medicaid will not make separate payment for these services under the day treatment program.

(4) Assessment services. All day treatment patients will receive a formal, comprehensive biopsychosocial assessment of day treatment needs including, if applicable, a diagnostic impression based on the current Diagnostic and Statistical Manual of Mental Disorders. An assessment from another source performed within the previous 12 months may be used if the symptomatology is the same as 12 months ago. If not, parts of the assessment which reflect current functioning may be used as an update. Using the assessment, a comprehensive summation will be produced, including the findings of all assessments performed. The summary will be used in forming a treatment plan including treatment goals. Indicators for discharge planning, including recommended follow-up goals and provision for future services, should also be considered, and consistently monitored.

(5) The day treatment program may include an educational component as an additional service. The patient's educational needs shall be served without conflict from the day treatment program. Hours

in which the patient is involved in the educational component of the day treatment program are not included in the day treatment hours billable to Medicaid.

d. Admission criteria. Admission criteria for day treatment services for persons aged 20 or under shall reflect the following clinical indicators:

- (1) The patient is at risk for exclusion from normative community activities or residence.
- (2) The patient exhibits psychiatric symptoms, disturbances of conduct, decompensating conditions affecting mental health, severe developmental delays, psychological symptoms, or chemical dependency issues sufficiently severe to bring about significant or profound impairment in day-to-day educational, social, vocational, or interpersonal functioning.
- (3) Documentation is provided that the traditional outpatient setting has been considered and has been determined not to be appropriate.
- (4) The patient's principal caretaker (family, guardian, foster family or custodian) must be able and willing to provide the support and monitoring of the patient, to enable adequate control of the patient's behavior, and must be involved in the patient's treatment. Persons aged 20 or under who have reached the age of majority, either by age or emancipation, are exempt from family therapy involvement.
- (5) The patient has the capacity to benefit from the interventions provided.

e. Individual treatment plan. Each patient receiving day treatment services shall have a treatment plan prepared. A preliminary treatment plan should be formulated within 3 days of participation after admission, and replaced within 30 calendar days by a comprehensive, formalized plan utilizing the comprehensive assessment. This individual treatment plan should reflect the patient's strengths and weaknesses and identify areas of therapeutic focus. The treatment goals which are general statements of consumer outcomes shall be related to identified strengths, weaknesses, and clinical needs with time-limited, measurable objectives. Objectives shall be related to the goal and have specific anticipated outcomes. Methods that will be used to pursue the objectives shall be stated. The plan should be reviewed and revised as needed, but shall be reviewed at least every 30 calendar days. The treatment plan shall be developed or approved by a board-eligible or board-certified psychiatrist, a staff psychiatrist, physician, or a psychologist registered either on the "National Register of Health Service Providers in Psychology" or the "Iowa Register of Health Service Providers for Psychology." Approval will be evidenced by a signature of the physician or health service provider.

f. Discharge criteria. Discharge criteria for the day treatment program for persons aged 20 or under shall incorporate at least the following indicators:

- (1) In the case of patient improvement:
 1. The patient's clinical condition has improved as shown by symptom relief, behavioral control, or indication of mastery of skills at the patient's developmental level. Reduced interference with and increased responsibility with social, vocational, interpersonal, or educational goals occurs sufficient to warrant a treatment program of less supervision, support, and therapeutic intervention.
 2. Treatment goals in the individualized treatment plan have been achieved.
 3. An aftercare plan has been developed that is appropriate to the patient's needs and agreed to by the patient and family, custodian, or guardian.
- (2) If the patient does not improve:
 1. The patient's clinical condition has deteriorated to the extent that the safety and security of inpatient or residential care is necessary.
 2. Patient, family, or custodian noncompliance with treatment or with program rules exists.

g. Coordination of services. Programming services shall be provided in accordance with the individual treatment plan developed by appropriate day treatment staff, in collaboration with the patient and appropriate caretaker figure (parent, guardian, or principal caretaker), and under the supervision of the program director, coordinator, or supervisor.

The program for each patient will be coordinated by primary care staff of the community mental health center. A coordinated, consistent array of scheduled therapeutic services and activities shall comprise the day treatment program. These may include counseling or psychotherapy, theme groups, social skills development, behavior management, and other adjunctive therapies. At least 50 percent of scheduled therapeutic program hours exclusive of educational hours for each patient shall consist

of active treatment that specifically addresses the targeted problems of the population served. Active treatment shall be defined as treatment in which the program staff assume significant responsibility and often intervene.

Family, guardian, or principal caretaker shall be involved with the program through family therapy sessions or scheduled family components of the program. They will be encouraged to adopt an active role in treatment. Medicaid will not make separate payment for family therapy services. Persons aged 20 or under who have reached the age of majority, either by age or emancipation, are exempt from family therapy involvement.

Therapeutic activities will be scheduled according to the needs of the patients, both individually and as a group.

Scheduled therapeutic activities, which may include other program components as described above, shall be provided at least 3 hours per week up to a maximum of 15 hours per week.

h. Stable milieu. The program shall formally seek to provide a stable, consistent, and cohesive therapeutic milieu. In part this will be encouraged by scheduling attendance such that a stable core of patients exists as much as possible. The milieu will consider the developmental and social stage of the participants such that no patient will be significantly involved with other patients who are likely to contribute to retardation or deterioration of the patient's social and emotional functioning. To help establish a sense of program identity, the array of therapeutic interventions shall be specifically identified as the day treatment program. Program planning meetings shall be held at least quarterly to evaluate the effectiveness of the clinical program. In the program description, the provider shall state how milieu stability will be provided.

i. Chronic mental illness. Persons aged 18 through 20 with chronic mental illness as defined by rule 441—24.1(225C) can receive day treatment services under this subrule or subrule 78.16(6).

This rule is intended to implement Iowa Code section 249A.4.

441—78.17(249A) Physical therapists. Payment will be approved for the same services payable under Title XVIII of the Social Security Act (Medicare).

This rule is intended to implement Iowa Code section 249A.4.

441—78.18(249A) Screening centers. Payment will be approved for health screening as defined in 441—subrule 84.1(1) for Medicaid members under 21 years of age.

78.18(1) In order to be paid for the administration of a vaccine covered under the Vaccines for Children (VFC) Program, a screening center must enroll in the VFC program. Payment for the vaccine will be approved only if the VFC program stock has been depleted.

78.18(2) Payment will be approved for necessary laboratory service related to an element of screening when performed by the screening center and billed as a separate item.

78.18(3) Periodicity schedules for health, hearing, vision, and dental screenings.

a. Payment will be approved for health, vision, and hearing screenings as follows:

- (1) Six screenings in the first year of life.
- (2) Four screenings between the ages of 1 and 2.
- (3) One screening a year at ages 3, 4, 5, and 6.
- (4) One screening a year at ages 8, 10, 12, 14, 16, 18, and 20.

b. Payment for dental screenings will be approved in conjunction with the health screenings up to age 12 months. Screenings will be approved at ages 12 months and 24 months and thereafter at six-month intervals up to age 21.

c. Interperiodic screenings will be approved as medically necessary.

78.18(4) When it is established by the periodicity schedule in 78.18(3) that an individual is in need of screening the individual will receive a notice that screening is due.

78.18(5) When an individual is screened, a member of the screening center shall complete a medical history. The medical history shall become part of the individual's medical record.

78.18(6) Rescinded IAB 12/3/08, effective 2/1/09.

78.18(7) Payment will be made for persons aged 20 and under for nutritional counseling provided by a licensed dietitian employed by or under contract with a screening center for a nutritional problem or condition of a degree of severity that nutritional counseling beyond that normally expected as part of the standard medical management is warranted. For persons eligible for the WIC program, a WIC referral is required. Medical necessity for nutritional counseling services exceeding those available through WIC shall be documented.

78.18(8) Payment shall be made for dental services provided by a dental hygienist employed by or under contract with a screening center.

This rule is intended to implement Iowa Code section 249A.4.

[ARC 0065C, IAB 4/4/12, effective 6/1/12]

441—78.19(249A) Rehabilitation agencies.

78.19(1) Coverage of services.

a. General provisions regarding coverage of services.

(1) Services are provided in the member's home or in a care facility (other than a hospital) by a speech therapist, physical therapist, or occupational therapist employed by or contracted by the agency. Services provided to a member residing in a residential care facility are payable when the facility submits a signed statement that the facility does not have these services available. The statement need only be submitted at the start of care unless the situation changes. Payment will not be made to a rehabilitation agency for therapy provided to a member residing in a nursing facility or an intermediate care facility for persons with an intellectual disability since these facilities are responsible for providing or paying for services required by members.

(2) All services must be determined to be medically necessary, reasonable, and meet a significant need of the recipient that cannot be met by a family member, friend, medical staff personnel, or other caregiver; must meet accepted standards of medical practice; and must be a specific and effective treatment for a patient's medical or disabling condition.

(3) In order for a service to be payable, a licensed therapist must complete a plan of treatment every 30 days and indicate the type of service required. The plan of treatment must contain the information noted in subrule 78.19(2).

(4) There is no specific limitation on the number of visits for which payment through the program will be made so long as that amount of service is medically necessary in the individual case, is related to a diagnosed medical impairment or disabling condition, and meets the current standards of practice in each related field. Documentation must be submitted with each claim to support the need for the number of services being provided.

(5) Payments will be made both for restorative service and also for maintenance types of service. Essentially, maintenance services means services to a patient whose condition is stabilized and who requires observation by a therapist of conditions defined by the physician as indicating a possible deterioration of health status. This would include persons with long-term illnesses or a disabling condition whose status is stable rather than posthospital. Refer to 78.19(1) "b"(7) and (8) for guidelines under restorative and maintenance therapy.

(6) Restorative or maintenance therapy sessions must meet the following criteria:

1. There must be face-to-face patient contact interaction.

2. Services must be provided primarily on an individual basis. Group therapy is covered, but total units of service in a month shall not exceed total units of individual therapy. Family members receiving therapy may be included as part of a group.

3. Treatment sessions may be no less than 15 minutes of service and no more than 60 minutes of service per date unless more than 60 minutes of service is required for a treatment session due to the patient's specific condition. If more than 60 minutes of service is required for a treatment session, additional documentation of the specific condition and the need for the longer treatment session shall be submitted with the claim. A unit of treatment shall be considered to be 15 minutes in length.

4. Progress must be documented in measurable statistics in the progress notes in order for services to be reimbursed. Refer to 78.19(1)“b”(7) and (8) for guidelines under restorative and maintenance therapy.

(7) Payment will be made for an appropriate period of diagnostic therapy or trial therapy (up to two months) to determine a patient’s rehabilitation potential and establish appropriate short-term and long-term goals. Documentation must be submitted with each plan to support the need for diagnostic or trial therapy. Refer to 78.19(1)“b”(16) for guidelines under diagnostic or trial therapy.

b. Physical therapy services.

(1) To be covered under rehabilitation agency services, physical therapy services must relate directly and specifically to an active written treatment plan, follow a treatment plan established by the licensed therapist after consultation with the physician, be reasonable and necessary to the treatment of the person’s illness, injury, or disabling condition, be specific and effective treatment for the patient’s medical or disabling condition, and be of such a level of complexity and sophistication, or the condition of the patient must be such that the services required can be safely and effectively performed only by a qualified physical therapist or under the supervision of the therapist.

(2) A qualified physical therapist assistant may provide any restorative services performed by a licensed physical therapist under supervision of the therapist as set forth in the department of public health, professional licensure division, 645—subrule 200.20(7).

(3) The initial physical therapy evaluation must be provided by a licensed physical therapist.

(4) There must be an expectation that there will be a significant, practical improvement in the patient’s condition in a reasonable amount of time based on the patient’s restorative potential assessed by the physician.

(5) It must be demonstrated there is a need to establish a safe and effective maintenance program related to a specific disease state, illness, injury, or disabling condition.

(6) The amount, frequency, and duration of the services must be reasonable.

(7) Restorative therapy must be reasonable and necessary to the treatment of the patient’s injury or disabling condition. The expected restorative potential must be practical and in relation to the extent and duration of the treatment. There must be an expectation that the patient’s medical or disabling condition will show functional improvement in a reasonable period of time. Functional improvement means that demonstrable measurable increases have occurred in the patient’s level of independence outside the therapeutic environment.

(8) Generally, maintenance therapy means services to a patient whose condition is stabilized and who requires observation by a therapist of conditions defined by the physician as indicating a possible deterioration of health status. This includes persons with long-term illnesses or disabling conditions whose status is stable rather than posthospital. Maintenance therapy is also appropriate for individuals whose condition is such that a professionally established program of activities, exercises, or stimulation is medically necessary to prevent deterioration or maintain present functioning levels.

Where a maintenance program is appropriate, the initial evaluation and the instruction of the patient, family members, home health aides, facility personnel, or other caregivers to carry out the program are considered a covered physical therapy service. Payment shall be made for a maximum of three visits to establish a maintenance program and instruct the caregivers. Payment for supervisory visits to monitor the program is limited to two per month for a maximum period of 12 months. The plan of treatment must specify the anticipated monitoring activity of the supervisor.

Beyond evaluation, instruction, and monitoring, maintenance therapy is not reimbursable.

After 12 months of maintenance therapy, a reevaluation is a covered service, if medically necessary. A reevaluation will be considered medically necessary only if there is a significant change in residential or employment situation or the patient exhibits an increase or decrease in functional ability or motivation, clearing of confusion, or the remission of some other medical condition which previously contraindicated restorative therapy. A statement by the interdisciplinary team of a person with developmental disabilities recommending a reevaluation and stating the basis for medical necessity will be considered as supporting the necessity of a reevaluation and may expedite approval.

(Restorative and maintenance therapy definitions also apply to speech and occupational therapy.)

When a patient is under a restorative physical therapy program, the patient's condition is regularly reevaluated and the program adjusted by the physical therapist. It is expected that prior to discharge, a maintenance program has been designed by the physical therapist. Consequently, where a maintenance program is not established until after the restorative program has been completed, it would not be considered reasonable and necessary to the treatment of the patient's condition and would be excluded from coverage.

(9) Hot packs, hydrocollator, infrared treatments, paraffin baths, and whirlpool baths do not ordinarily require the skills of a qualified physical therapist. These are covered when the patient's condition is complicated by other conditions such as a circulatory deficiency or open wounds or if the service is an integral part of a skilled physical therapy procedure.

(10) Gait training and gait evaluation and training constitute a covered service if the patient's ability to walk has been impaired by a neurological, muscular or skeletal condition or illness. The gait training must be expected to significantly improve the patient's ability to walk or level of independence.

Repetitious exercise to increase endurance of weak or unstable patients can be safely provided by supportive personnel, e.g., aides, nursing personnel. Therefore, it is not a covered physical therapy service.

(11) Ultrasound, shortwave, and microwave diathermy treatments are considered covered services.

(12) Range of motion tests must be performed by a qualified physical therapist. Range of motion exercises require the skills of a qualified physical therapist only when they are part of the active treatment of a specific disease or disabling condition which has resulted in a loss or restriction of mobility.

Documentation must reflect the degree of motion lost, the normal range of motion, and the degree to be restored.

Range of motion to unaffected joints only does not constitute a covered physical therapy service.

(13) Reconditioning programs after surgery or prolonged hospitalization are not covered as physical therapy.

(14) Therapeutic exercises would constitute a physical therapy service due either to the type of exercise employed or to the condition of the patient.

(15) Use of isokinetic or isotonic type equipment in physical therapy is covered when normal range of motion of a joint is affected due to bone, joint, ligament or tendon injury or postsurgical trauma. Billing can only be made for the time actually spent by the therapist in instructing the patient and assessing the patient's progress.

(16) When recipients do not meet restorative or maintenance therapy criteria, diagnostic or trial therapy may be utilized. When the initial evaluation is not sufficient to determine whether there are rehabilitative goals that should be addressed, diagnostic or trial therapy to establish goals shall be considered appropriate. Diagnostic or trial therapy may be appropriate for recipients who need evaluation in multiple environments in order to adequately determine their rehabilitative potential. Diagnostic or trial therapy consideration may be appropriate when there is a need to assess the patient's response to treatment in the recipient's environment.

When during diagnostic or trial therapy a recipient has been sufficiently evaluated to determine potential for restorative or maintenance therapy, or lack of therapy potential, diagnostic or trial therapy ends. When as a result of diagnostic or trial therapy, restorative or maintenance therapy is found appropriate, claims shall be submitted noting restorative or maintenance therapy (instead of diagnostic or trial therapy).

At the end of diagnostic or trial therapy, the rehabilitation provider shall recommend continuance of services under restorative therapy, recommend continuance of services under maintenance therapy, or recommend discontinuance of services. Continuance of services under restorative or maintenance therapy will be reviewed based on the criteria in place for restorative or maintenance therapy.

Trial therapy shall not be granted more often than once per year for the same issue. If the recipient has a previous history of rehabilitative services, trial therapy for the same type of services generally would be payable only when a significant change has occurred since the last therapy. Requests for subsequent diagnostic or trial therapy for the same issue would require documentation reflecting a significant change. See number 4 below for guidelines under a significant change. Further diagnostic or trial therapy for the

same issue would not be considered appropriate when progress was not achieved, unless the reasons which blocked change previously are listed and the reasons the new diagnostic or trial therapy would not have these blocks are provided.

The number of diagnostic or trial therapy hours authorized in the initial treatment period shall not exceed 12 hours per month. Documentation of the medical necessity and the plan for services under diagnostic trial therapy are required as they will be reviewed in the determination of the medical necessity of the number of hours of service provided.

Diagnostic or trial therapy standards also apply to speech and occupational therapy.

The following criteria additionally must be met:

1. There must be face-to-face interaction with a licensed therapist. (An aide's services will not be payable.)

2. Services must be provided on an individual basis. (Group diagnostic or trial therapy will not be payable.)

3. Documentation of the diagnostic therapy or trial therapy must reflect the provider's plan for therapy and the recipient's response.

4. If the recipient has a previous history of rehabilitative services, trial therapy for the same type of services generally would be payable only when a significant change has occurred since the last therapy. A significant change would be considered as having occurred when any of the following exist: new onset, new problem, new need, new growth issue, a change in vocational or residential setting that requires a reevaluation of potential, or surgical intervention that may have caused new rehabilitative potentials.

5. For persons who received previous rehabilitative treatment, consideration of trial therapy generally should occur only if the person has incorporated any regimen recommended during prior treatment into the person's daily life to the extent of the person's abilities.

6. Documentation should include any previous attempts to resolve problems using nontherapy personnel (i.e., residential group home staff, family members, etc.) and whether follow-up programs from previous therapy have been carried out.

7. Referrals from residential, vocational or other rehabilitation personnel that do not meet present evaluation, restorative or maintenance criteria shall be considered for trial therapy. Documentation of the proposed service, the medical necessity and the current medical or disabling condition, including any secondary rehabilitative diagnosis, will need to be submitted with the claim.

8. Claims for diagnostic or trial therapy shall reflect the progress being made toward the initial diagnostic or trial therapy plan.

c. Occupational therapy services.

(1) To be covered under rehabilitation agency services, occupational therapy services must be included in a plan of treatment, improve or restore practical functions which have been impaired by illness, injury, or disabling condition, or enhance the person's ability to perform those tasks required for independent functioning, be prescribed by a physician under a plan of treatment, be performed by a qualified licensed occupational therapist or a qualified licensed occupational therapist assistant under the general supervision of a qualified licensed occupational therapist as set forth in the department of public health, professional licensure division, rule 645—201.9(148B), and be reasonable and necessary for the treatment of the person's illness, injury, or disabling condition.

(2) Restorative therapy is covered when an expectation exists that the therapy will result in a significant practical improvement in the person's condition.

However, in these cases where there is a valid expectation of improvement met at the time the occupational therapy program is instituted, but the expectation goal is not realized, services would only be covered up to the time one would reasonably conclude the patient would not improve.

The guidelines under restorative therapy, maintenance therapy, and diagnostic or trial therapy for physical therapy in 78.19(1) "b" (7), (8), and (16) apply to occupational therapy.

(3) Maintenance therapy, or any activity or exercise program required to maintain a function at the restored level, is not a covered service. However, designing a maintenance program in accordance with the requirements of 78.19(1) "b" (8) and monitoring the progress would be covered.

(4) The selection and teaching of tasks designed to restore physical function are covered.

(5) Planning and implementing therapeutic tasks, such as activities to restore sensory-integrative functions are covered. Other examples include providing motor and tactile activities to increase input and improve responses for a stroke patient.

(6) The teaching of activities of daily living and energy conservation to improve the level of independence of a patient which require the skill of a licensed therapist and meet the definition of restorative therapy is covered.

(7) The designing, fabricating, and fitting of orthotic and self-help devices are considered covered services if they relate to the patient's condition and require occupational therapy. A maximum of 13 visits is reimbursable.

(8) Vocational and prevocational assessment and training are not payable by Medicaid. These include services which are related solely to specific employment opportunities, work skills, or work settings.

d. Speech therapy services.

(1) To be covered by Medicaid as rehabilitation agency services, speech therapy services must be included in a plan of treatment established by the licensed, skilled therapist after consultation with the physician, relate to a specific medical diagnosis which will significantly improve a patient's practical, functional level in a reasonable and predictable time period, and require the skilled services of a speech therapist. Services provided by a speech aide are not reimbursable.

(2) Speech therapy activities which are considered covered services include: restorative therapy services to restore functions affected by illness, injury, or disabling condition resulting in a communication impairment or to develop functions where deficiencies currently exist. Communication impairments fall into the general categories of disorders of voice, fluency, articulation, language, and swallowing disorders resulting from any condition other than mental impairment. Treatment of these conditions is payable if restorative criteria are met.

(3) Aural rehabilitation, the instruction given by a qualified speech pathologist in speech reading or lip reading to patients who have suffered a hearing loss (input impairment), constitutes a covered service if reasonable and necessary to the patient's illness or injury. Group treatment is not covered. Audiological services related to the use of a hearing aid are not reimbursable.

(4) Teaching a patient to use sign language and to use an augmentative communication device is reimbursable. The patient must show significant progress outside the therapy sessions in order for these services to be reimbursable.

(5) Where a maintenance program is appropriate, the initial evaluation, the instruction of the patient and caregivers to carry out the program, and supervisory visits to monitor progress are covered services. Beyond evaluation, instruction, and monitoring, maintenance therapy is not reimbursable. However, designing a maintenance program in accordance with the requirements of maintenance therapy and monitoring the progress are covered.

(6) The guidelines and limits on restorative therapy, maintenance therapy, and diagnostic or trial therapy for physical therapy in 78.19(1) "b"(7), (8), and (16) apply to speech therapy. If the only goal of prior rehabilitative speech therapy was to learn the prerequisite speech components, then number "5" under 78.19(1) "b"(16) will not apply to trial therapy.

78.19(2) General guidelines for plans of treatment.

a. The minimum information to be included on medical information forms and treatment plans includes:

(1) The patient's current medical condition and functional abilities, including any disabling condition.

(2) The physician's signature and date (within the certification period).

(3) Certification period.

(4) Patient's progress in measurable statistics. (Refer to 78.19(1) "b"(16).)

(5) The place services are rendered.

(6) Dates of prior hospitalization (if applicable or known).

(7) Dates of prior surgery (if applicable or known).

(8) The date the patient was last seen by the physician (if available).

- (9) A diagnosis relevant to the medical necessity for treatment.
- (10) Dates of onset of any diagnoses for which treatment is being rendered (if applicable).
- (11) A brief summary of the initial evaluation or baseline.
- (12) The patient's prognosis.
- (13) The services to be rendered.
- (14) The frequency of the services and discipline of the person providing the service.
- (15) The anticipated duration of the services and the estimated date of discharge (if applicable).
- (16) Assistive devices to be used.
- (17) Functional limitations.
- (18) The patient's rehabilitative potential and the extent to which the patient has been able to apply the skills learned in the rehabilitation setting to everyday living outside the therapy sessions.
- (19) The date of the last episode of instability or the date of the last episode of acute recurrence of illness or symptoms (if applicable).
- (20) Quantitative, measurable, short-term and long-term functional goals.
- (21) The period of time of a session.
- (22) Prior treatment (history related to current diagnosis) if available or known.

b. The information to be included when developing plans for teaching, training, and counseling include:

- (1) To whom the services were provided (patient, family member, etc.).
- (2) Prior teaching, training, or counseling provided.
- (3) The medical necessity of the rendered services.
- (4) The identification of specific services and goals.
- (5) The date of the start of the services.
- (6) The frequency of the services.
- (7) Progress in response to the services.
- (8) The estimated length of time the services are needed.

This rule is intended to implement Iowa Code section 249A.4.

[ARC 0994C, IAB 9/4/13, effective 11/1/13]

441—78.20(249A) Independent laboratories. Payment will be made for medically necessary laboratory services provided by laboratories that are independent of attending and consulting physicians' offices, hospitals, and critical access hospitals and that are certified to participate in the Medicare program.

This rule is intended to implement Iowa Code section 249A.4.

441—78.21(249A) Rural health clinics. Payment will be made to rural health clinics for the same services payable under the Medicare program (Title XVIII of the Social Security Act). Payment will be made for sterilization in accordance with 78.1(16).

78.21(1) Utilization review. Utilization review shall be conducted of Medicaid members who access more than 24 outpatient visits in any 12-month period from physicians, advanced registered nurse practitioners, federally qualified health centers, other clinics, and emergency rooms. Refer to rule 441—76.9(249A) for further information concerning the member lock-in program.

78.21(2) Risk assessment. Risk assessment, using Form 470-2942, Medicaid Prenatal Risk Assessment, shall be completed at the initial visit during a Medicaid member's pregnancy.

a. If the risk assessment reflects a low-risk pregnancy, the assessment shall be completed again at approximately the twenty-eighth week of pregnancy.

b. If the risk assessment reflects a high-risk pregnancy, referral shall be made for enhanced services. (See description of enhanced services at subrule 78.25(3).)

78.21(3) Vaccines. In order to be paid for the administration of a vaccine covered under the Vaccines for Children (VFC) Program, a rural health center must enroll in the VFC program. Payment for the vaccine will be approved only if the VFC program stock has been depleted.

This rule is intended to implement Iowa Code section 249A.4.

[ARC 0065C, IAB 4/4/12, effective 6/1/12]

441—78.22(249A) Family planning clinics. Payments will be made on a fee schedule basis for services provided by family planning clinics.

78.22(1) Payment will be made for sterilization in accordance with 78.1(16).

78.22(2) In order to be paid for the administration of a vaccine covered under the Vaccines for Children (VFC) Program, a family planning clinic must enroll in the VFC program. Payment for the vaccine will be approved only if the VFC program stock has been depleted.

This rule is intended to implement Iowa Code section 249A.4.

[ARC 0065C, IAB 4/4/12, effective 6/1/12]

441—78.23(249A) Other clinic services. Payment will be made on a fee schedule basis to facilities not part of a hospital, funded publicly or by private contributions, which provide medically necessary treatment by or under the direct supervision of a physician or dentist to outpatients.

78.23(1) Sterilization. Payment will be made for sterilization in accordance with 78.1(16).

78.23(2) Utilization review. Utilization review shall be conducted of Medicaid members who access more than 24 outpatient visits in any 12-month period from physicians, advanced registered nurse practitioners, federally qualified health centers, other clinics, and emergency rooms. Refer to rule 441—76.9(249A) for further information concerning the member lock-in program.

78.23(3) Risk assessment. Risk assessment, using Form 470-2942, Medicaid Prenatal Risk Assessment, shall be completed at the initial visit during a Medicaid member's pregnancy.

a. If the risk assessment reflects a low-risk pregnancy, the assessment shall be completed again at approximately the twenty-eighth week of pregnancy.

b. If the risk assessment reflects a high-risk pregnancy, referral shall be made for enhanced services. (See description of enhanced services at subrule 78.25(3).)

78.23(4) Vaccines. In order to be paid for the administration of a vaccine covered under the Vaccines for Children (VFC) Program, a clinic must enroll in the VFC program. Payment for the vaccine will be approved only if the VFC program stock has been depleted.

This rule is intended to implement Iowa Code section 249A.4.

[ARC 0065C, IAB 4/4/12, effective 6/1/12]

441—78.24(249A) Psychologists. Payment will be approved for services authorized by state law when they are provided by the psychologist in the psychologist's office, a hospital, nursing facility, or residential care facility.

78.24(1) Payment for covered services provided by the psychologist shall be made on a fee for service basis.

a. Payment shall be made only for time spent in face-to-face consultation with the client.

b. Time spent with clients shall be rounded to the quarter hour.

78.24(2) Payment will be approved for the following psychological procedures:

a. Individual outpatient psychotherapy or other psychological procedures not to exceed one hour per week or 40 hours in any 12-month period, or

b. Couple, marital, family, or group outpatient therapy not to exceed one and one-half hours per week or 60 hours in any 12-month period, or

c. A combination of individual and group therapy not to exceed the cost of 40 individual therapy hours in any 12-month period.

d. Psychological examinations and testing for purposes of evaluation, placement, psychotherapy, or assessment of therapeutic progress, not to exceed eight hours in any 12-month period.

e. Mileage at the same rate as in 78.1(8) when the following conditions are met:

(1) It is necessary for the psychologist to travel outside of the home community, and

(2) There is no qualified mental health professional more immediately available in the community,

and

(3) The member has a medical condition which prohibits travel.

f. Covered procedures necessary to maintain continuity of psychological treatment during periods of hospitalization or convalescence for physical illness.

g. Procedures provided within a licensed hospital, residential treatment facility, day hospital, or nursing home as part of an approved treatment plan and a psychologist is not employed by the facility.

78.24(3) Payment will not be approved for the following services:

- a. Psychological examinations performed without relationship to evaluations or psychotherapy for a specific condition, symptom, or complaint.
- b. Psychological examinations covered under Part B of Medicare, except for the Part B Medicare deductible and coinsurance.
- c. Psychological examinations employing unusual or experimental instrumentation.
- d. Individual and group psychotherapy without specification of condition, symptom, or complaint.
- e. Sensitivity training, marriage enrichment, assertiveness training, growth groups or marathons, or psychotherapy for nonspecific conditions of distress such as job dissatisfaction or general unhappiness.

78.24(4) Rescinded IAB 10/12/94, effective 12/1/94.

78.24(5) The following services shall require review by a consultant to the department.

- a. Protracted therapy beyond 16 visits. These cases shall be reviewed following the sixteenth therapy session and periodically thereafter.
- b. Any service which does not appear necessary or appears to fall outside the scope of what is professionally appropriate or necessary for a particular condition.

This rule is intended to implement Iowa Code sections 249A.4 and 249A.15.

441—78.25(249A) Maternal health centers. Payment will be made for prenatal and postpartum medical care, health education, and transportation to receive prenatal and postpartum services. Payment will be made for enhanced perinatal services for persons determined high risk. These services include additional health education services, nutrition counseling, social services, and one postpartum home visit. Maternal health centers shall provide trimester and postpartum reports to the referring physician. Risk assessment using Form 470-2942, Medicaid Prenatal Risk Assessment, shall be completed at the initial visit during a Medicaid member's pregnancy. If the risk assessment reflects a low-risk pregnancy, the assessment shall be completed again at approximately the twenty-eighth week of pregnancy. If the risk assessment reflects a high-risk pregnancy, referral shall be made for enhanced services. (See description of enhanced services at subrule 78.25(3).)

78.25(1) Provider qualifications.

- a. Prenatal and postpartum medical services shall be provided by a physician, a physician assistant, or a nurse practitioner employed by or on contract with the center. Medical services performed by maternal health centers shall be performed under the supervision of a physician. Nurse practitioners and physician assistants performing under the supervision of a physician must do so within the scope of practice of that profession, as defined by Iowa Code chapters 152 and 148C, respectively.
- b. Rescinded IAB 12/3/08, effective 2/1/09.
- c. Education services and postpartum home visits shall be provided by a registered nurse.
- d. Nutrition services shall be provided by a licensed dietitian.
- e. Psychosocial services shall be provided by a person with at least a bachelor's degree in social work, counseling, sociology, psychology, family and community services, health or human development, health education, or individual and family studies.

78.25(2) Services covered for all pregnant women. Services provided may include:

- a. Prenatal and postpartum medical care.
- b. Health education, which shall include:
 - (1) Importance of continued prenatal care.
 - (2) Normal changes of pregnancy including both maternal changes and fetal changes.
 - (3) Self-care during pregnancy.
 - (4) Comfort measures during pregnancy.
 - (5) Danger signs during pregnancy.
 - (6) Labor and delivery including the normal process of labor, signs of labor, coping skills, danger signs, and management of labor.
 - (7) Preparation for baby including feeding, equipment, and clothing.

- (8) Education on the use of over-the-counter drugs.
- (9) Education about HIV protection.
- c. Home visit.
- d. Transportation to receive prenatal and postpartum services that is not payable under rule 441—78.11(249A) or 441—78.13(249A).
- e. Dental hygiene services within the scope of practice as defined by the dental board at 650—paragraph 10.5(3)“b.”

78.25(3) *Enhanced services covered for women with high-risk pregnancies.* Enhanced perinatal services may be provided to a patient who has been determined to have a high-risk pregnancy as documented by Form 470-2942, Medicaid Prenatal Risk Assessment. An appropriately trained physician or advanced registered nurse practitioner must be involved in staffing the patients receiving enhanced services.

Enhanced services are as follows:

- a. Rescinded IAB 12/3/08, effective 2/1/09.
- b. Education, which shall include as appropriate education about the following:
 - (1) High-risk medical conditions.
 - (2) High-risk sexual behavior.
 - (3) Smoking cessation.
 - (4) Alcohol usage education.
 - (5) Drug usage education.
 - (6) Environmental and occupational hazards.
- c. Nutrition assessment and counseling, which shall include:
 - (1) Initial assessment of nutritional risk based on height, current and prepregnancy weight status, laboratory data, clinical data, and self-reported dietary information.
 - (2) Ongoing nutritional assessment.
 - (3) Development of an individualized nutritional care plan.
 - (4) Referral to food assistance programs if indicated.
 - (5) Nutritional intervention.
- d. Psychosocial assessment and counseling, which shall include:
 - (1) A psychosocial assessment including: needs assessment, profile of client demographic factors, mental and physical health history and concerns, adjustment to pregnancy and future parenting, and environmental needs.
 - (2) A profile of the client's family composition, patterns of functioning and support systems.
 - (3) An assessment-based plan of care, risk tracking, counseling and anticipatory guidance as appropriate, and referral and follow-up services.
- e. A postpartum home visit within two weeks of the child's discharge from the hospital, which shall include:
 - (1) Assessment of mother's health status.
 - (2) Physical and emotional changes postpartum.
 - (3) Family planning.
 - (4) Parenting skills.
 - (5) Assessment of infant health.
 - (6) Infant care.
 - (7) Grief support for unhealthy outcome.
 - (8) Parenting of a preterm infant.
 - (9) Identification of and referral to community resources as needed.

78.25(4) *Vaccines.* In order to be paid for the administration of a vaccine covered under the Vaccines for Children (VFC) Program, a maternal health center must enroll in the VFC program. Payment for the vaccine will be approved only if the VFC program stock has been depleted.

This rule is intended to implement Iowa Code section 249A.4.

[ARC 0065C, IAB 4/4/12, effective 6/1/12]

441—78.26(249A) Ambulatory surgical center services. Ambulatory surgical center services are those services furnished by an ambulatory surgical center in connection with a covered surgical procedure or a covered dental procedure. Covered procedures are listed in the fee schedule published on the department's Web site.

78.26(1) Covered surgical procedures shall be those medically necessary procedures that are eligible for payment as physicians' services, under the circumstances specified in rule 441—78.1(249A) and performed on a Medicaid member, that can safely be performed in an outpatient setting as determined by the department upon advice from the Iowa Medicaid enterprise medical services unit.

78.26(2) Covered dental procedures are those medically necessary procedures that are eligible for payment as dentists' services, under the circumstances specified in rule 441—78.4(249A) and performed on a Medicaid member, that can safely be performed in an outpatient setting for Medicaid members whose mental, physical, or emotional condition necessitates deep sedation or general anesthesia.

78.26(3) The covered services provided by the ambulatory surgical center in connection with a Medicaid-covered surgical or dental procedure shall be those nonsurgical and nondental services that:

- a. Are medically necessary in connection with a Medicaid-covered surgical or dental procedure;
- b. Are eligible for payment as physicians' services under the circumstances specified in rule 441—78.1(249A) or as dentists' services under the circumstances specified in rule 441—78.4(249A); and
- c. Can safely and economically be performed in an outpatient setting, as determined by the department upon advice from the Iowa Medicaid enterprise medical services unit.

78.26(4) Limits on covered services.

- a. Abortion procedures are covered only when criteria in subrule 78.1(17) are met.
- b. Sterilization procedures are covered only when criteria in subrule 78.1(16) are met.
- c. Preprocedure review by the Iowa Foundation for Medical Care (IFMC) is required if ambulatory surgical centers are to be reimbursed for certain frequently performed surgical procedures as set forth under subrule 78.1(19). Criteria are available from IFMC, 1776 West Lakes Parkway, West Des Moines, Iowa 50266-8239, or in local hospital utilization review offices. (Cross-reference 78.28(6))

This rule is intended to implement Iowa Code section 249A.4.

[ARC 8205B, IAB 10/7/09, effective 11/11/09]

441—78.27(249A) Home- and community-based habilitation services. Payment for habilitation services will only be made to providers enrolled to provide habilitation through the Iowa Plan for Behavioral Health.

78.27(1) Definitions.

"Adult" means a person who is 18 years of age or older.

"Assessment" means the review of the current functioning of the member using the service in regard to the member's situation, needs, strengths, abilities, desires, and goals.

"Care coordinator" means the professional who assists members in care coordination as described in paragraph 78.53(1) "b."

"Case management" means case management services accredited under 441—Chapter 24 and provided according to 441—Chapter 90.

"Comprehensive service plan" means an individualized, goal-oriented plan of services written in language understandable by the member using the service and developed collaboratively by the member and the case manager.

"Department" means the Iowa department of human services.

"Emergency" means a situation for which no approved individual program plan exists that, if not addressed, may result in injury or harm to the member or to other persons or in significant amounts of property damage.

"HCBS" means home- and community-based services.

"Integrated health home" means the provision of services to enrolled members as described in subrule 78.53(1).

“Interdisciplinary team” means a group of persons with varied professional backgrounds who meet with the member to develop a comprehensive service plan to address the member’s need for services.

“ISIS” means the department’s individualized services information system.

“Member” means a person who has been determined to be eligible for Medicaid under 441—Chapter 75.

“Program” means a set of related resources and services directed to the accomplishment of a fixed set of goals for qualifying members.

78.27(2) Member eligibility. To be eligible to receive home- and community-based habilitation services, a member shall meet the following criteria:

a. Risk factors. The member has at least one of the following risk factors:

(1) The member has undergone or is currently undergoing psychiatric treatment more intensive than outpatient care (e.g., emergency services, alternative home care, partial hospitalization, or inpatient hospitalization) more than once in the member’s life; or

(2) The member has a history of psychiatric illness resulting in at least one episode of continuous, professional supportive care other than hospitalization.

b. Need for assistance. The member has a need for assistance demonstrated by meeting at least two of the following criteria on a continuing or intermittent basis for at least two years:

(1) The member is unemployed, is employed in a sheltered setting, or has markedly limited skills and a poor work history.

(2) The member requires financial assistance for out-of-hospital maintenance and is unable to procure this assistance without help.

(3) The member shows severe inability to establish or maintain a personal social support system.

(4) The member requires help in basic living skills such as self-care, money management, housekeeping, cooking, and medication management.

(5) The member exhibits inappropriate social behavior that results in a demand for intervention.

c. Income. The countable income used in determining the member’s Medicaid eligibility does not exceed 150 percent of the federal poverty level.

d. Needs assessment. The member’s case manager or integrated health home care coordinator has completed an assessment of the member’s need for service, and, based on that assessment, the Iowa Medicaid enterprise medical services unit or the Iowa Plan for Behavioral Health contractor has determined that the member is in need of home- and community-based habilitation services. A member who is not eligible for integrated health home services shall receive Medicaid case management under 441—Chapter 90 as a home- and community-based habilitation service. The designated case manager or integrated health home care coordinator shall:

(1) Complete a needs-based evaluation that meets the standards for assessment established in 441—subrule 90.5(1) before services begin and annually thereafter.

(2) Use the evaluation results to develop a comprehensive service plan as specified in subrule 78.27(4).

e. Plan for service. The department or the Iowa Plan for Behavioral Health contractor has approved the member’s plan for home- and community-based habilitation services. Home- and community-based habilitation services included in a comprehensive service plan or treatment plan that has been validated through ISIS or in a treatment plan that has been authorized by the Iowa Plan for Behavioral Health contractor shall be considered approved by the department. Home- and community-based habilitation services provided before approval of a member’s eligibility for the program cannot be reimbursed.

(1) The member’s comprehensive service plan shall be completed annually according to the requirements of subrule 78.27(4). A service plan may change at any time due to a significant change in the member’s needs.

(2) The member’s habilitation services shall not exceed the maximum number of units established for each service in 441—subrule 79.1(2).

(3) The cost of the habilitation services shall not exceed unit expense maximums established in 441—subrule 79.1(2).

f. Iowa Plan for Behavioral Health eligibility. Members eligible to enroll in the Iowa Plan for Behavioral Health shall be eligible to receive home- and community-based habilitation services only through the Iowa Plan for Behavioral Health.

78.27(3) Application for services. The member, case manager or integrated health home care coordinator shall apply for habilitation services on behalf of a member by contacting the Iowa Plan for Behavioral Health contractor or by entering a program request for habilitation services in ISIS for members who are not eligible to enroll in the Iowa Plan for Behavioral Health for any reason. The department or the Iowa Plan for Behavioral Health contractor shall issue a notice of decision to the applicant when financial eligibility, determination of needs-based eligibility, and approval of the comprehensive service plan or treatment plan have been completed.

78.27(4) Comprehensive service plan. Individualized, planned, and appropriate services shall be guided by a member-specific comprehensive service plan or treatment plan developed with the member in collaboration with an interdisciplinary team, as appropriate. Medically necessary services shall be planned for and provided at the locations where the member lives, learns, works, and socializes.

a. Development. A comprehensive service plan or treatment plan shall be developed for each member receiving home- and community-based habilitation services based on the member's current assessment and shall be reviewed on an annual basis.

(1) The case manager or the integrated health home care coordinator shall establish an interdisciplinary team for the member. The team shall include the case manager or integrated health home care coordinator and the member and, if applicable, the member's legal representative, the member's family, the member's service providers, and others directly involved.

(2) With the interdisciplinary team, the case manager or integrated health home care coordinator shall identify the member's services based on the member's needs, the availability of services, and the member's choice of services and providers.

(3) The comprehensive service plan development shall be completed at the member's home or at another location chosen by the member.

(4) The interdisciplinary team meeting shall be conducted before the current comprehensive service plan expires.

(5) The comprehensive service plan shall reflect desired individual outcomes.

(6) Services defined in the comprehensive service plan shall be appropriate to the severity of the member's problems and to the member's specific needs or disabilities.

(7) Activities identified in the comprehensive service plan shall encourage the ability and right of the member to make choices, to experience a sense of achievement, and to modify or continue participation in the treatment process.

(8) For members receiving home-based habilitation in a licensed residential care facility of 16 or fewer beds, the service plan shall address the member's opportunities for independence and community integration.

(9) The initial comprehensive service plan or treatment plan and annual updates to the comprehensive service plan or treatment plan must be approved by the Iowa Plan for Behavioral Health contractor, or by the Iowa Medicaid enterprise for members who are not eligible to enroll in the Iowa Plan for Behavioral Health, in the individualized services information system before services are implemented. Services provided before the approval date are not payable. The written comprehensive service plan or treatment plan must be completed, signed and dated by the case manager, integrated health home care coordinator, or service worker within 30 calendar days after plan approval.

(10) Any changes to the comprehensive service plan or treatment plan must be approved by the Iowa Plan for Behavioral Health contractor, or by the Iowa Medicaid enterprise for members not eligible to enroll in the Iowa Plan for Behavioral Health, in the individualized services information system before the implementation of services. Services provided before the approval date are not payable.

b. Service goals and activities. The comprehensive service plan shall:

(1) Identify observable or measurable individual goals.

(2) Identify interventions and supports needed to meet those goals with incremental action steps, as appropriate.

(3) Identify the staff persons, businesses, or organizations responsible for carrying out the interventions or supports.

(4) List all Medicaid and non-Medicaid services received by the member and identify:

1. The name of the provider responsible for delivering the service;
2. The funding source for the service; and
3. The number of units of service to be received by the member.

(5) Identify for a member receiving home-based habilitation:

1. The member's living environment at the time of enrollment;
2. The number of hours per day of on-site staff supervision needed by the member; and
3. The number of other members who will live with the member in the living unit.

(6) Include a separate, individualized, anticipated discharge plan that is specific to each service the member receives.

c. Rights restrictions. Any rights restrictions must be implemented in accordance with 441—subrule 77.25(4). The comprehensive service plan or treatment plan shall include documentation of:

- (1) Any restrictions on the member's rights, including maintenance of personal funds and self-administration of medications;
- (2) The need for the restriction; and
- (3) Either a plan to restore those rights or written documentation that a plan is not necessary or appropriate.

d. Emergency plan. The comprehensive service plan or treatment plan shall include a plan for emergencies and identification of the supports available to the member in an emergency. Emergency plans shall be developed as follows:

(1) The member's interdisciplinary team shall identify in the comprehensive service plan or treatment plan any health and safety issues applicable to the individual member based on information gathered before the team meeting, including a risk assessment.

(2) The interdisciplinary team shall identify an emergency backup support and crisis response system to address problems or issues arising when support services are interrupted or delayed or the member's needs change.

(3) Providers of applicable services shall provide for emergency backup staff.

e. Plan approval.

(1) A treatment plan that has been validated and authorized by the Iowa Plan for Behavioral Health contractor shall be considered approved.

(2) For members who are not Iowa Plan-eligible, services shall be entered into ISIS based on the comprehensive service plan. A comprehensive service plan or treatment plan that has been validated and authorized through ISIS shall be considered approved by the department. Services must be authorized in ISIS as specified in paragraph 78.27(2) "e."

78.27(5) Requirements for services. Home- and community-based habilitation services shall be provided in accordance with the following requirements:

a. The services shall be based on the member's needs as identified in the member's comprehensive service plan.

b. The services shall be delivered in the least restrictive environment appropriate to the needs of the member.

c. The services shall include the applicable and necessary instruction, supervision, assistance, and support required by the member to achieve the member's life goals.

d. Service components that are the same or similar shall not be provided simultaneously.

e. Service costs are not reimbursable while the member is in a medical institution, including but not limited to a hospital or nursing facility.

f. Reimbursement is not available for room and board.

g. Services shall be billed in whole units.

h. Services shall be documented. Each unit billed must have corresponding financial and medical records as set forth in rule 441—79.3(249A).

78.27(6) Case management. Case management assists members in gaining access to needed medical, social, educational, housing, transportation, vocational, and other appropriate services in order to ensure the health, safety, and welfare of the member.

a. Scope. Case management services shall be provided as set forth in rules 441—90.5(249A) and 441—90.8(249A).

b. Exclusions.

(1) Payment shall not be made for case management provided to a member who is enrolled for integrated health home services under rule 441—78.53(249A) except during the transition to the integrated health homes.

(2) Payment shall not be made for case management provided to a member who is eligible for case management services under 441—Chapter 90.

78.27(7) Home-based habilitation. “Home-based habilitation” means individually tailored supports that assist with the acquisition, retention, or improvement of skills related to living in the community.

a. Scope. Home-based habilitation services are individualized supportive services provided in the member’s home and community that assist the member to reside in the most integrated setting appropriate to the member’s needs. Services are intended to provide for the daily living needs of the member and shall be available as needed during any 24-hour period. The specific support needs for each member shall be determined necessary by the interdisciplinary team and shall be identified in the member’s comprehensive service plan. Covered supports include:

- (1) Adaptive skill development;
- (2) Assistance with activities of daily living;
- (3) Community inclusion;
- (4) Transportation;
- (5) Adult educational supports;
- (6) Social and leisure skill development;
- (7) Personal care; and
- (8) Protective oversight and supervision.

b. Exclusions. Home-based habilitation payment shall not be made for the following:

(1) Room and board and maintenance costs, including the cost of rent or mortgage, utilities, telephone, food, household supplies, and building maintenance, upkeep, or improvement.

(2) Service activities associated with vocational services, day care, medical services, or case management.

(3) Transportation to and from a day program.

(4) Services provided to a member who lives in a licensed residential care facility of more than 16 persons.

(5) Services provided to a member who lives in a facility that provides the same service as part of an inclusive or “bundled” service rate, such as a nursing facility or an intermediate care facility for persons with mental retardation.

(6) Personal care and protective oversight and supervision may be a component part of home-based habilitation services but may not comprise the entirety of the service.

78.27(8) Day habilitation. “Day habilitation” means assistance with acquisition, retention, or improvement of self-help, socialization, and adaptive skills.

a. Scope. Day habilitation activities and environments are designed to foster the acquisition of skills, appropriate behavior, greater independence, and personal choice. Services focus on enabling the member to attain or maintain the member’s maximum functional level and shall be coordinated with any physical, occupational, or speech therapies in the comprehensive service plan. Services may serve to reinforce skills or lessons taught in other settings. Services must enhance or support the member’s:

- (1) Intellectual functioning;
- (2) Physical and emotional health and development;
- (3) Language and communication development;
- (4) Cognitive functioning;
- (5) Socialization and community integration;

- (6) Functional skill development;
- (7) Behavior management;
- (8) Responsibility and self-direction;
- (9) Daily living activities;
- (10) Self-advocacy skills; or
- (11) Mobility.

b. Setting. Day habilitation shall take place in a nonresidential setting separate from the member's residence. Services shall not be provided in the member's home. When the member lives in a residential care facility of more than 16 beds, day habilitation services provided in the facility are not considered to be provided in the member's home if the services are provided in an area apart from the member's sleeping accommodations.

c. Duration. Day habilitation services shall be furnished for four or more hours per day on a regularly scheduled basis for one or more days per week or as specified in the member's comprehensive service plan. Meals provided as part of day habilitation shall not constitute a full nutritional regimen (three meals per day).

d. Exclusions. Day habilitation payment shall not be made for the following:

- (1) Vocational or prevocational services.
- (2) Services that duplicate or replace education or related services defined in Public Law 94-142, the Education of the Handicapped Act.
- (3) Compensation to members for participating in day habilitation services.

78.27(9) *Prevocational habilitation.* "Prevocational habilitation" means services that prepare a member for paid or unpaid employment.

a. Scope. Prevocational habilitation services include teaching concepts such as compliance, attendance, task completion, problem solving, and safety. Services are not oriented to a specific job task, but instead are aimed at a generalized result. Services shall be reflected in the member's comprehensive service plan and shall be directed to habilitative objectives rather than to explicit employment objectives.

b. Setting. Prevocational habilitation services may be provided in a variety of community-based settings based on the individual need of the member. Meals provided as part of these services shall not constitute a full nutritional regimen (three meals per day).

c. Exclusions. Prevocational habilitation payment shall not be made for the following:

- (1) Services that are available under a program funded under Section 110 of the Rehabilitation Act of 1973 or the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.). Documentation that funding is not available for the service under these programs shall be maintained in the file of each member receiving prevocational habilitation services.
- (2) Services that duplicate or replace education or related services defined in Public Law 94-142, the Education of the Handicapped Act.
- (3) Compensation to members for participating in prevocational services.

78.27(10) *Supported employment habilitation.* "Supported employment habilitation" means services associated with maintaining competitive paid employment.

a. Scope. Supported employment habilitation services are intensive, ongoing supports that enable members to perform in a regular work setting. Services are provided to members who need support because of their disabilities and who are unlikely to obtain competitive employment at or above the minimum wage absent the provision of supports. Covered services include:

- (1) Activities to obtain a job. Covered services directed to obtaining a job must be provided to or on behalf of a member for whom competitive employment is reasonably expected within less than one year. Services must be focused on job placement, not on teaching generalized employment skills or habilitative goals. Three conditions must be met before services are provided. First, the member and the interdisciplinary team described in subrule 78.27(4) must complete the form that Iowa vocational rehabilitation services uses to identify the supported employment services appropriate to meet a person's employment needs. Second, the member's interdisciplinary team must determine that the identified

services are necessary. Third, the Iowa Medicaid enterprise medical services unit must approve the services. Available components of activities to obtain a job are as follows:

1. Job development services. Job development services are directed toward obtaining competitive employment. A unit of service is a job placement that the member holds for 30 consecutive calendar days or more. Payment is available once the service is authorized in the member's service plan. A member may receive two units of job development services during a 12-month period. The activities provided to the member may include job procurement training, including grooming and hygiene, application, résumé development, interviewing skills, follow-up letters, and job search activities; job retention training, including promptness, coworker relations, transportation skills, disability-related supports, job benefits, and an understanding of employee rights and self-advocacy; and customized job development services specific to the member.

2. Employer development services. The focus of employer development services is to support employers in hiring and retaining members in their workforce and to communicate expectations of the employers to the interdisciplinary team described in subrule 78.27(4). Employer development services may be provided only to members who are reasonably expected to work for no more than 10 hours per week. A unit of service is one job placement that the member holds for 30 consecutive calendar days or more. Payment for this service may be made only after the member holds the job for 30 days. A member may receive two units of employer development services during a 12-month period if the member is competitively employed for 30 or more consecutive calendar days and the other conditions for service approval are met. The services provided may include: developing relationships with employers and providing leads for individual members when appropriate; job analysis for a specific job; development of a customized training plan identifying job-specific skill requirements, employer expectations, teaching strategies, time frames, and responsibilities; identifying and arranging reasonable accommodations with the employer; providing disability awareness and training to the employer when it is deemed necessary; and providing technical assistance to the employer regarding the training progress as identified on the member's customized training plan.

3. Enhanced job search activities. Enhanced job search activities are associated with obtaining initial employment after job development services have been provided to the member for a minimum of 30 days or with assisting the member in changing jobs due to layoff, termination, or personal choice. The interdisciplinary team must review and update the Iowa vocational rehabilitation services supported employment readiness analysis form to determine if this service remains appropriate for the member's employment goals. A unit of service is 15 minutes. A maximum of 104 units may be provided in a 12-month period. The services provided may include: job opening identification with the member; assistance with applying for a job, including completion of applications or interviews; and work site assessment and job accommodation evaluation.

(2) Supports to maintain employment, including the following services provided to or on behalf of the member:

1. Individual work-related behavioral management.
 2. Job coaching.
 3. On-the-job or work-related crisis intervention.
 4. Assistance in the use of skills related to sustaining competitive paid employment, including assistance with communication skills, problem solving, and safety.
 5. Assistance with time management.
 6. Assistance with appropriate grooming.
 7. Employment-related supportive contacts.
 8. On-site vocational assessment after employment.
 9. Employer consultation.
- b. *Setting.* Supported employment may be conducted in a variety of settings, particularly work sites where persons without disabilities are employed.

(1) The majority of coworkers at any employment site with more than two employees where members seek, obtain, or maintain employment must be persons without disabilities.

(2) In the performance of job duties at any site where members seek, obtain, or maintain employment, the member must have daily contact with other employees or members of the general public who do not have disabilities, unless the absence of daily contact with other employees or the general public is typical for the job as performed by persons without disabilities.

(3) When services for maintaining employment are provided to members in a teamwork or “enclave” setting, the team shall include no more than eight people with disabilities.

c. Service requirements. The following requirements shall apply to all supported employment services:

(1) All supported employment services shall provide individualized and ongoing support contacts at intervals necessary to promote successful job retention.

(2) The provider shall provide employment-related adaptations required to assist the member in the performance of the member’s job functions as part of the service.

(3) Community transportation options (such as carpools, coworkers, self or public transportation, families, volunteers) shall be attempted before the service provider provides transportation. When no other resources are available, employment-related transportation between work and home and to or from activities related to employment may be provided as part of the service.

(4) Members may access both services to maintain employment and services to obtain a job for the purpose of job advancement or job change. A member may receive a maximum of three job placements in a 12-month period and a maximum of 40 units per week of services to maintain employment.

d. Exclusions. Supported employment habilitation payment shall not be made for the following:

(1) Services that are available under a program funded under Section 110 of the Rehabilitation Act of 1973 or the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.). Documentation that funding is not available under these programs shall be maintained in the file of each member receiving supported employment services.

(2) Incentive payments made to an employer to encourage or subsidize the employer’s participation in a supported employment program.

(3) Subsidies or payments that are passed through to users of supported employment programs.

(4) Training that is not directly related to a member’s supported employment program.

(5) Services involved in placing or maintaining members in day activity programs, work activity programs, or sheltered workshop programs.

(6) Supports for volunteer work or unpaid internships.

(7) Tuition for education or vocational training.

(8) Individual advocacy that is not member-specific.

78.27(11) Adverse service actions.

a. Denial. Services shall be denied when the department or the Iowa Plan for Behavioral Health contractor determines that:

(1) The member is not eligible for or in need of home- and community-based habilitation services.

(2) The service is not identified in the member’s comprehensive service plan or treatment plan.

(3) Needed services are not available or received from qualifying providers, or no qualifying providers are available.

(4) The member’s service needs exceed the unit or reimbursement maximums for a service as set forth in 441—subrule 79.1(2).

(5) Completion or receipt of required documents for the program has not occurred.

b. Reduction. A particular home- and community-based habilitation service may be reduced when the department or the Iowa Plan for Behavioral Health contractor determines that continued provision of service at its current level is not necessary.

c. Termination. A particular home- and community-based habilitation service may be terminated when the department or the Iowa Plan for Behavioral Health contractor determines that:

(1) The member’s income exceeds the allowable limit, or the member no longer meets other eligibility criteria for the program established by the department.

(2) The service is not identified in the member’s comprehensive service plan.

(3) Needed services are not available or received from qualifying providers, or no qualifying providers are available.

(4) The member's service needs are not being met by the services provided.

(5) The member has received care in a medical institution for 30 consecutive days in any one stay. When a member has been an inpatient in a medical institution for 30 consecutive days, the department or the Iowa Plan for Behavioral Health contractor will issue a notice of decision to inform the member of the service termination. If the member returns home before the effective date of the notice of decision and the member's condition has not substantially changed, the decision shall be rescinded, and eligibility for home- and community-based habilitation services shall continue.

(6) The member's service needs exceed the unit or reimbursement maximums for a service as established by the department.

(7) Duplication of services provided during the same period has occurred.

(8) The member or the member's legal representative, through the interdisciplinary process, requests termination of the service.

(9) Completion or receipt of required documents for the program has not occurred, or the member refuses to allow documentation of eligibility as to need and income.

d. Appeal rights.

(1) The Iowa Plan for Behavioral Health contractor shall give notice of any adverse action and the right to appeal in accordance with 441—Chapter 7.

(2) The department shall give notice of any adverse action and the right to appeal in accordance with 441—Chapter 7. The member is entitled to have a review of the determination of needs-based eligibility by the Iowa Medicaid enterprise medical services unit by sending a letter requesting a review to the medical services unit. If dissatisfied with that decision, the member may file an appeal with the department.

78.27(12) County reimbursement. Rescinded IAB 7/11/12, effective 7/1/12.

This rule is intended to implement Iowa Code section 249A.4.

[ARC 7957B, IAB 7/15/09, effective 7/1/09 (See Delay note at end of chapter); ARC 9311B, IAB 12/29/10, effective 1/1/11; ARC 9403B, IAB 3/9/11, effective 5/1/11; ARC 0191C, IAB 7/11/12, effective 7/1/12; ARC 0359C, IAB 10/3/12, effective 12/1/12; ARC 0709C, IAB 5/1/13, effective 7/1/13; ARC 0848C, IAB 7/24/13, effective 7/1/13; ARC 1051C, IAB 10/2/13, effective 11/6/13]

441—78.28(249A) List of medical services and equipment requiring prior authorization, preprocedure review or preadmission review.

78.28(1) Services, procedures, and medications prescribed by a physician, physician assistant, or advanced registered nurse practitioner which are subject to prior authorization or preprocedure review are as follows or as specified in the preferred drug list published by the department pursuant to Iowa Code section 249A.20A:

a. Drugs require prior authorization as specified in the preferred drug list published by the department pursuant to Iowa Code section 249A.20A. For drugs requiring prior authorization, reimbursement will be made for a 72-hour supply dispensed in an emergency when a prior authorization request cannot be submitted.

b. Automated medication dispenser. Payment shall be approved pursuant to the criteria at 78.10(5) "*d.*"

c. Enteral products and enteral delivery pumps and supplies. Payment shall be approved pursuant to the criteria at 78.10(5) "*i.*"

d. Rescinded IAB 5/11/05, effective 5/1/05.

e. Speech generating device. Payment shall be approved pursuant to the criteria at 78.10(5) "*f.*"

f. Preprocedure review by the Iowa Foundation for Medical Care (IFMC) will be required if payment under Medicaid is to be made for certain frequently performed surgical procedures which have a wide variation in the relative frequency the procedures are performed. Preprocedure surgical review applies to surgeries performed in hospitals (outpatient and inpatient) and ambulatory surgical centers. Approval by IFMC will be granted only if the procedures are determined to be necessary based on the condition of the patient and on the published criteria established by the department and the IFMC. If not so approved by the IFMC, payment will not be made under the program to the physician or to the facility

in which the surgery is performed. The criteria are available from IFMC, 3737 Woodland Avenue, Suite 500, West Des Moines, Iowa 50265, or in local hospital utilization review offices.

The "Preprocedure Surgical Review List" shall be published by the department in the provider manuals for physicians, hospitals, and ambulatory surgical centers. (Cross-reference 78.1(19))

- g.* Enclosed beds. Payment shall be approved pursuant to the criteria at 78.10(5) "a."
- h.* Prior authorization is required for external insulin infusion pumps and is granted according to Medicare coverage criteria. (Cross-reference 78.10(2) "c")
- i.* Oral nutritional products. Payment shall be approved pursuant to the criteria at 78.10(5) "m."
- j.* Vest airway clearance system. Payment shall be approved pursuant to the criteria at 78.10(5) "c."
- k.* Diabetic equipment and supplies. Payment will be approved pursuant to the criteria at 78.10(5) "e."
- l.* Reimbursement over the established Medicaid fee schedule amount. Payment shall be approved pursuant to the criteria at 78.10(5) "n."
- m.* Bathtub/shower chair, bench. Payment shall be approved pursuant to the criteria at 78.10(5) "g."
- n.* Patient lift, nonstandard. Payment shall be approved pursuant to the criteria at 78.10(5) "h."
- o.* Power wheelchair attendant control. Payment shall be approved pursuant to the criteria at 78.10(5) "i."
- p.* Shower commode chair. Payment shall be approved pursuant to the criteria at 78.10(5) "j."
- q.* Ventilator, secondary. Payment shall be approved pursuant to the Medicare coverage criteria.
- r.* Customized wheelchairs for members who are residents of nursing facilities, subject to the requirements of 78.10(2) "a"(4).

78.28(2) Dental services. Dental services which require prior approval are as follows:

- a.* The following periodontal services:
 - (1) Periodontal scaling and root planing. Payment will be approved pursuant to the criteria at 78.4(4) "b."
 - (2) Pedicle soft tissue graft, free soft tissue graft, and subepithelial tissue graft. Payment will be approved pursuant to the criteria at 78.4(4) "d."
 - (3) Periodontal maintenance therapy. Payment will be approved pursuant to the criteria at 78.4(4) "e."
 - (4) Tissue regeneration. Payment will be approved pursuant to the criteria at 78.4(4) "f."
 - (5) Localized delivery of antimicrobial agents. Payment will be approved pursuant to the criteria at 78.4(4) "g."
- b.* The following prosthetic services:
 - (1) A removable partial denture replacing anterior teeth. Payment will be approved pursuant to the criteria at 78.4(7) "b."
 - (2) A fixed partial denture replacing anterior teeth. Payment will be approved pursuant to the criteria at 78.4(7) "d."
 - (3) A removable partial denture replacing posterior teeth. Payment will be approved pursuant to the criteria at 78.4(7) "c."
 - (4) A fixed partial denture replacing posterior teeth. Payment will be approved pursuant to the criteria at 78.4(7) "e."
 - (5) Dental implants and related services. Payment will be approved pursuant to the criteria at 78.4(7) "k."
 - (6) Replacement of complete or partial dentures in less than a five-year period. Payment will be approved pursuant to the criteria at 78.4(7) "l."
 - (7) A complete or partial denture rebase. Payment will be approved pursuant to the criteria at 78.4(7) "m."
 - (8) An oral appliance for obstructive sleep apnea. Payment will be approved pursuant to the criteria at 78.4(7) "n."
- c.* The following orthodontic services:

(1) Minor treatment to control harmful habits. Payment will be approved pursuant to the criteria at 78.4(8)“a.”

(2) Interceptive orthodontic treatment. Payment will be approved pursuant to the criteria at 78.4(8)“b.”

(3) Comprehensive orthodontic treatment. Payment will be approved pursuant to the criteria at 78.4(8)“c.”

d. The following restorative services:

(1) Laboratory-fabricated crowns other than stainless steel. Payment will be approved pursuant to the criteria at 78.4(3)“d”(3).

(2) Crowns with noble or high noble metals. Payment will be approved pursuant to the criteria at 78.4(3)“d”(4).

e. Endodontic retreatment of a tooth. Payment will be approved pursuant to the criteria at 78.4(5)“d.”

f. Occlusal guard. Payment will be approved pursuant to the criteria at 78.4(9)“g.”

78.28(3) Optometric services and ophthalmic materials which must be submitted for prior approval are as follows:

a. A second lens correction within a 24-month period for members eight years of age and older. Payment shall be made when the member’s vision has at least a five-tenths diopter of change in sphere or cylinder or ten-degree change in axis in either eye.

b. Visual therapy may be authorized when warranted by case history or diagnosis for a period of time not greater than 90 days. Should continued therapy be warranted, the prior approval process should be reaccomplished, accompanied by a report showing satisfactory progress. Approved diagnoses are convergence insufficiency and amblyopia. Visual therapy is not covered when provided by opticians.

c. Subnormal visual aids where near visual acuity is better than 20/100 at 16 inches, 2M print. Prior authorization is not required if near visual acuity as described above is less than 20/100. Subnormal aids include, but are not limited to, hand magnifiers, loupes, telescopic spectacles or reverse Galilean telescope systems.

d. Photochromatic tint. Approval shall be given when the member has a documented medical condition that causes photosensitivity and less costly alternatives are inadequate.

e. Press-on prisms. Approval shall be granted for members whose vision cannot be adequately corrected with other covered prisms.

For all of the above, the optometrist shall furnish sufficient information to clearly establish that these procedures are necessary in terms of the visual condition of the patient. (Cross-references 78.6(4), 441—78.7(249A), and 78.1(18))

78.28(4) Hearing aids that must be submitted for prior approval are:

a. Replacement of a hearing aid less than four years old (except when the member is under 21 years of age). The department shall approve payment when the original hearing aid is lost or broken beyond repair or there is a significant change in the person’s hearing that would require a different hearing aid. (Cross-reference 78.14(7)“d”(1))

b. A hearing aid costing more than \$650. The department shall approve payment for either of the following purposes (Cross-reference 78.14(7)“d”(2)):

(1) Educational purposes when the member is participating in primary or secondary education or in a postsecondary academic program leading to a degree and an in-office comparison of an analog aid and a digital aid matched (+/- 5dB) for gain and output shows a significant improvement in either speech recognition in quiet or speech recognition in noise or an in-office comparison of two aids, one of which is single channel, shows significantly improved audibility.

(2) Vocational purposes when documentation submitted indicates the necessity, such as varying amounts of background noise in the work environment and a need to converse in order to do the job and an in-office comparison of an analog aid and a digital aid matched (+/- 5dB) for gain and output shows a significant improvement in either speech recognition in quiet or speech recognition in noise or an in-office comparison of two aids, one of which is single channel, shows significantly improved audibility.

78.28(5) Hospital services which must be subject to prior approval, preprocedure review or preadmission review are:

a. Any medical or surgical procedure requiring prior approval as set forth in Chapter 78 is subject to the conditions for payment set forth although a request form does not need to be submitted by the hospital as long as the approval is obtained by the physician. (Cross-reference 441—78.1(249A))

b. All inpatient hospital admissions are subject to preadmission review. Payment for inpatient hospital admissions is approved when it meets the criteria for inpatient hospital care as determined by the IFMC or its delegated hospitals. Criteria are available from IFMC, 6000 Westown Parkway, Suite 350E, West Des Moines, Iowa 50265-7771, or in local hospital utilization review offices. (Cross-reference 441—78.3(249A))

c. Preprocedure review by the IFMC is required if hospitals are to be reimbursed for the inpatient and outpatient surgical procedures set forth in subrule 78.1(19). Approval by the IFMC will be granted only if the procedures are determined to be necessary based on the condition of the patient and the criteria established by the department and IFMC. The criteria are available from IFMC, 6000 Westown Parkway, Suite 350E, West Des Moines, Iowa 50265-7771, or in local hospital utilization review offices.

78.28(6) Ambulatory surgical centers are subject to prior approval and preprocedure review as follows:

a. Any medical or surgical procedure requiring prior approval as set forth in Chapter 78 is subject to the conditions for payment set forth although a request form does not need to be submitted by the ambulatory surgical center as long as the prior approval is obtained by the physician.

b. Preprocedure review by the IFMC is required if ambulatory surgical centers are to be reimbursed for surgical procedures as set forth in subrule 78.1(19). Approval by the IFMC will be granted only if the procedures are determined to be necessary based on the condition of the patient and criteria established by the IFMC and the department. The criteria are available from IFMC, 6000 Westown Parkway, Suite 350E, West Des Moines, Iowa 50265-7771, or in local hospital utilization review offices.

78.28(7) All assertive community treatment (ACT) services require prior approval. EXCEPTION: If ACT services are initiated before Medicaid eligibility is established, prior approval is required for ACT services beginning with the second month following notice of Medicaid eligibility.

a. Approval shall be granted if ACT services are determined to be medically necessary. Approval shall be limited to no more than 180 days.

b. A new prior approval must be obtained to continue ACT services after the expiration of a previous approval.

78.28(8) Rescinded IAB 1/3/96, effective 3/1/96.

78.28(9) Private duty nursing or personal care services provided by a home health agency provider for persons aged 20 or under require prior approval and shall be approved if determined to be medically necessary. Payment shall be made on an hourly unit of service.

a. Definitions.

(1) Private duty nursing services are those services which are provided by a registered nurse or a licensed practical nurse under the direction of the member's physician to a member in the member's place of residence or outside the member's residence, when normal life activities take the member outside the place of residence. Place of residence does not include nursing facilities, intermediate care facilities for the mentally retarded, or hospitals.

Services shall be provided according to a written plan of care authorized by a licensed physician. The home health agency is encouraged to collaborate with the member, or in the case of a child with the child's caregiver, in the development and implementation of the plan of treatment. These services shall exceed intermittent guidelines as defined in subrule 78.9(3). Private duty nursing and personal care services shall be inclusive of all home health agency services personally provided to the member.

Private duty nursing services do not include:

1. Respite care, which is a temporary intermission or period of rest for the caregiver.
2. Nurse supervision services including chart review, case discussion or scheduling by a registered nurse.

3. Services provided to other persons in the member's household.
4. Services requiring prior authorization that are provided without regard to the prior authorization process.

(2) Personal care services are those services provided by a home health aide or certified nurse's aide and which are delegated and supervised by a registered nurse under the direction of the member's physician to a member in the member's place of residence or outside the member's residence, when normal life activities take the member outside the place of residence. Place of residence does not include nursing facilities, intermediate care facilities for the mentally retarded, or hospitals. Payment for personal care services for persons aged 20 and under that exceed intermittent guidelines may be approved if determined to be medically necessary as defined in subrule 78.9(7). These services shall be in accordance with the member's plan of care and authorized by a physician. The home health agency is encouraged to collaborate with the member, or in the case of a child with the child's caregiver, in the development and implementation of the plan of treatment.

Medical necessity means the service is reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent the worsening of conditions that endanger life, cause pain, result in illness or infirmity, threaten to cause or aggravate a disability or chronic illness, and no other equally effective course of treatment is available or suitable for the member requesting a service.

b. Requirements.

(1) Private duty nursing or personal care services shall be ordered in writing by a physician as evidenced by the physician's signature on the plan of care.

(2) Private duty nursing or personal care services shall be authorized by the department or the department's designated review agent prior to payment.

(3) Prior authorization shall be requested at the time of initial submission of the plan of care or at any time the plan of care is substantially amended and shall be renewed with the department or the department's designated review agent. Initial request for and request for renewal of prior authorization shall be submitted to the department's designated review agent. The provider of the service is responsible for requesting prior authorization and for obtaining renewal of prior authorization.

The request for prior authorization shall include a nursing assessment, the plan of care, and supporting documentation. The request for prior authorization shall include all items previously identified as required treatment plan information and shall further include: any planned surgical interventions and projected time frame; information regarding caregiver's desire to become involved in the member's care, to adhere to program objectives, to work toward treatment plan goals, and to work toward maximum independence; and identify the types and service delivery levels of all other services to the member whether or not the services are reimbursable by Medicaid. Providers shall indicate the expected number of private duty nursing RN hours, private duty nursing LPN hours, or home health aide hours per day, the number of days per week, and the number of weeks or months of service per discipline. If the member is currently hospitalized, the projected date of discharge shall be included.

Prior authorization approvals shall not be granted for treatment plans that exceed 16 hours of home health agency services per day. (Cross-reference 78.9(10))

78.28(10) Replacement of vibrotactile aids less than four years old shall be approved when the original aid is broken beyond repair or lost. (Cross-reference 78.10(3) "b")

78.28(11) High-technology radiology procedures.

a. Except as provided in paragraph 78.28(11) "b," the following radiology procedures require prior approval:

- (1) Magnetic resonance imaging (MRIs);
- (2) Computed tomography (CTs), including combined abdomen and pelvis CT scans;
- (3) Computed tomographic angiographs (CTAs);
- (4) Positron emission tomography (PETs); and
- (5) Magnetic resonance angiography (MRAs).

b. Notwithstanding paragraph 78.28(11) "a," prior authorization is not required when any of the following applies:

(1) Radiology procedures are billed on a CMS 1500 claim for places of service “hospital inpatient” (POS 21) or “hospital emergency room” (POS 23), or on a UB04 claim with revenue code 45X;

(2) The member has Medicare coverage;

(3) The member received notice of retroactive Medicaid eligibility after receiving a radiology procedure at a time prior to the member’s receipt of such notice (see paragraph 78.28(11) “e”); or

(4) A radiology procedure is ordered or requested by the department of human services, a state district court, law enforcement, or other similar entity for the purposes of a child abuse/neglect investigation, as documented by the provider.

c. Prior approval will be granted if the procedure requested meets the requirements of 441—subrule 79.9(2), based on diagnosis, symptoms, history of illness, course of treatment, and treatment plan, as documented by the provider requesting prior approval.

d. Required requests for prior approval of radiology procedures must be submitted through the online system operated by the department’s contractor for prior approval of high-technology radiology procedures.

e. Services are billed for members with retroactive eligibility.

(1) When a member has received notice of retroactive Medicaid eligibility after receiving a radiology procedure for a date of service prior to the member’s receipt of such notice and otherwise requiring prior approval pursuant to this rule, a retroactive authorization request must be submitted on Form 470-0829, Request for Prior Authorization, before any claim for payment is submitted.

(2) Payment will be authorized only if the prior approval criteria were met and the service was provided to the member prior to the retroactive eligibility notification, as documented by the provider requesting retroactive authorization.

(3) Retroactive authorizations will not be granted when sought for reasons other than a member’s retroactive Medicaid eligibility. Examples of such reasons include, but are not limited to, the following:

1. The provider was unaware of the high-technology radiology prior authorization requirement.
2. The provider was unaware that the member had current Medicaid eligibility or coverage.
3. The provider forgot to complete the required prior authorization process.

This rule is intended to implement Iowa Code section 249A.4.

[ARC 7548B, IAB 2/11/09, effective 4/1/09; ARC 8714B, IAB 5/5/10, effective 5/1/10; ARC 9440B, IAB 4/6/11, effective 4/1/11; ARC 9702B, IAB 9/7/11, effective 9/1/11; ARC 9883B, IAB 11/30/11, effective 1/4/12; ARC 0305C, IAB 9/5/12, effective 11/1/12; ARC 0631C, IAB 3/6/13, effective 5/1/13; ARC 0632C, IAB 3/6/13, effective 5/1/13; ARC 0823C, IAB 7/10/13, effective 9/1/13; ARC 1151C, IAB 10/30/13, effective 1/1/14; ARC 1696C, IAB 10/29/14, effective 1/1/15]

441—78.29(249A) Behavioral health services. Payment shall be made for medically necessary behavioral health services provided by a participating marital and family therapist, independent social worker, master social worker, mental health counselor, or certified alcohol and drug counselor within the practitioner’s scope of practice pursuant to state law and subject to the limitations and exclusions set forth in this rule.

78.29(1) Limitations.

a. An assessment and a treatment plan are required.

b. Services provided by a licensed master social worker must be provided under the supervision of an independent social worker qualified to participate in the Medicaid program.

78.29(2) Exclusions. Payment will not be approved for the following services:

a. Services provided in a medical institution.

b. Services performed without relationship to a specific condition, risk factor, symptom, or complaint.

c. Services provided for nonspecific conditions of distress such as job dissatisfaction or general unhappiness.

d. Sensitivity training, marriage enrichment, assertiveness training, and growth groups or marathons.

78.29(3) Payment.

a. Payment shall be made only for time spent in face-to-face consultation with the member.

b. A unit of service is 15 minutes. Time spent with members shall be rounded to the quarter hour, where applicable.

This rule is intended to implement Iowa Code section 249A.4.

[ARC 9649B, IAB 8/10/11, effective 8/1/11]

441—78.30(249A) Birth centers. Payment will be made for prenatal, delivery, and postnatal services.

78.30(1) Risk assessment. Risk assessment, using Form 470-2942, Medicaid Prenatal Risk Assessment, shall be completed at the initial visit during a Medicaid member's pregnancy.

a. If the risk assessment reflects a low-risk pregnancy, the assessment shall be completed again at approximately the twenty-eighth week of pregnancy.

b. If the risk assessment reflects a high-risk pregnancy, referral shall be made for enhanced services. (See description of enhanced services at subrule 78.25(3).)

78.30(2) Vaccines. In order to be paid for the administration of a vaccine covered under the Vaccines for Children (VFC) Program, a birth center must enroll in the VFC program. Payment for the vaccine will be approved only if the VFC program stock has been depleted.

This rule is intended to implement Iowa Code section 249A.4.

[ARC 0065C, IAB 4/4/12, effective 6/1/12]

441—78.31(249A) Hospital outpatient services.

78.31(1) Covered hospital outpatient services. Payment will be approved only for the following outpatient hospital services and medical services when provided on the licensed premises of the hospital or pursuant to subrule 78.31(5). Hospitals with alternate sites approved by the department of inspections and appeals are acceptable sites. All outpatient services listed in paragraphs "g" to "m" are subject to a random sample retrospective review for medical necessity by the Iowa Foundation for Medical Care. All services may also be subject to a more intensive retrospective review if abuse is suspected. Services in paragraphs "a" to "f" shall be provided in hospitals on an outpatient basis and are subject to no further limitations except medical necessity of the service.

Services listed in paragraphs "g" to "m" shall be provided by hospitals on an outpatient basis and must be certified by the department before payment may be made. Other limitations apply to these services.

- a.* Emergency service.
- b.* Outpatient surgery.
- c.* Laboratory, X-ray and other diagnostic services.
- d.* General or family medicine.
- e.* Follow-up or after-care specialty clinics.
- f.* Physical medicine and rehabilitation.
- g.* Alcoholism and substance abuse.
- h.* Eating disorders.
- i.* Cardiac rehabilitation.
- j.* Mental health.
- k.* Pain management.
- l.* Diabetic education.
- m.* Pulmonary rehabilitation.
- n.* Nutritional counseling for persons aged 20 and under.

78.31(2) Requirements for all outpatient services.

a. Need for service. It must be clearly established that the service meets a documented need in the area served by the hospital. There must be documentation of studies completed, consultations with other health care facilities and health care professionals in the area, community leaders, and organizations to determine the need for the service and to tailor the service to meet that particular need.

b. Professional direction. All outpatient services must be provided by or at the direction and under the supervision of a medical doctor or osteopathic physician except for mental health services which may be provided by or at the direction and under the supervision of a medical doctor, osteopathic physician, or certified health service provider in psychology.

c. Goals and objectives. The goals and objectives of the program must be clearly stated. Paragraphs “d” and “f” and the organization and administration of the program must clearly contribute to the fulfillment of the stated goals and objectives.

d. Treatment modalities used. The service must employ multiple treatment modalities and professional disciplines. The modalities and disciplines employed must be clearly related to the condition or disease being treated.

e. Criteria for selection and continuing treatment of patients. The condition or disease which is proposed to be treated must be clearly stated. Any indications for treatment or contraindications for treatment must be set forth together with criteria for determining the continued medical necessity of treatment.

f. Length of program. There must be established parameters that limit the program either in terms of its overall length or in terms of number of visits, etc.

g. Monitoring of services. The services provided by the program must be monitored and evaluated to determine the degree to which patients are receiving accurate assessments and effective treatment.

The monitoring of the services must be an ongoing plan and systematic process to identify problems in patient care or opportunities to improve patient care.

The monitoring and evaluation of the services are based on the use of clinical indicators that reflect those components of patient care important to quality.

h. Vaccines. In order to be paid for the outpatient administration of a vaccine covered under the Vaccines for Children (VFC) Program, a hospital must enroll in the VFC program. Payment for the vaccine will be approved only if the VFC program stock has been depleted.

78.31(3) Application for certification. Hospital outpatient programs listed in subrule 78.31(1), paragraphs “g” to “m,” must submit an application to the Iowa Medicaid enterprise provider services unit for certification before payment will be made. The provider services unit will review the application against the requirements for the specific type of outpatient service and notify the provider whether certification has been approved.

Applications will consist of a narrative providing the following information:

a. Documented need for the program including studies, needs assessments, and consultations with other health care professionals.

b. Goals and objectives of the program.

c. Organization and staffing including how the program fits with the rest of the hospital, the number of staff, staff credentials, and the staff’s relationship to the program, e.g., hospital employee, contractual consultant.

d. Policies and procedures including admission criteria, patient assessment, treatment plan, discharge plan and postdischarge services, and the scope of services provided, including treatment modalities.

e. Any accreditations or other types of approvals from national or state organizations.

f. The physical facility and any equipment to be utilized, and whether the facility is part of the hospital license.

78.31(4) Requirements for specific types of service.

a. Alcoholism and substance abuse.

(1) Approval by joint commission or substance abuse commission. In addition to certification by the department, alcoholism and substance abuse programs must also be approved by either the joint commission on the accreditation of hospitals or the Iowa substance abuse commission.

(2) General characteristics. The services must be designed to identify and respond to the biological, psychological and social antecedents, influences and consequences associated with the recipient’s dependence.

These needed services must be provided either directly by the facility or through referral, consultation or contractual arrangements or agreements.

Special treatment needs of recipients by reason of age, gender, sexual orientation, or ethnic origin are evaluated and services for children and adolescents (as well as adults, if applicable) address the

special needs of these age groups, including but not limited to, learning problems in education, family involvement, developmental status, nutrition, and recreational and leisure activities.

(3) Diagnostic and treatment staff. Each person who provides diagnostic or treatment services shall be determined to be competent to provide the services by reason of education, training, and experience.

Professional disciplines which must be represented on the diagnostic and treatment staff, either through employment by the facility (full-time or part-time), contract or referral, are a physician (M.D. or D.O.), a licensed psychologist and a substance abuse counselor certified by the Iowa board of substance abuse certification. Psychiatric consultation must be available and the number of staff should be appropriate to the patient load of the facility.

(4) Initial assessment. A comprehensive assessment of the biological, psychological, social, and spiritual orientation of the patient must be conducted which shall include:

A history of the use of alcohol and other drugs including age of onset, duration, patterns, and consequences of use; use of alcohol and drugs by family members and types of and responses to previous treatment.

A comprehensive medical history and physical examination including the history of physical problems associated with dependence.

Appropriate laboratory screening tests based on findings of the history and physical examination and tests for communicable diseases when indicated.

Any history of physical abuse.

A systematic mental status examination with special emphasis on immediate recall and recent and remote memory.

A determination of current and past psychiatric and psychological abnormality.

A determination of any degree of danger to self or others.

The family's history of alcoholism and other drug dependencies.

The patient's educational level, vocational status, and job performance history.

The patient's social support networks, including family and peer relationships.

The patient's perception of the patient's strengths, problem areas, and dependencies.

The patient's leisure, recreational, or vocational interests and hobbies.

The patient's ability to participate with peers and in programs and social activities.

Interview of family members and significant others as available with the patient's written or verbal permission.

Legal problems, if applicable.

(5) Admission criteria. Both of the first two criteria and one additional criterion from the following list must be present for a patient to be accepted for treatment.

Alcohol or drugs taken in greater amounts over a longer period than the person intended.

Two or more unsuccessful efforts to cut down or control use of alcohol or drugs.

Continued alcohol or drug use despite knowledge of having a persistent or recurrent family, social, occupational, psychological, or physical problem that is caused or exacerbated by the use of alcohol or drugs.

Marked tolerance: the need for markedly increased amounts of alcohol or drugs (i.e., at least a 50 percent increase) in order to achieve intoxication or desired effect or markedly diminished effect with continued use of same amount.

Characteristic withdrawal symptoms.

Alcohol or drugs taken often to relieve or avoid withdrawal symptoms.

(6) Plan of treatment. For each patient there is a written comprehensive and individualized description of treatment to be undertaken. The treatment plan is based on the problems and needs identified in the assessment and specifies the regular times at which the plan will be reassessed.

The patient's perception of needs and, when appropriate and available, the family's perception of the patient's needs shall be documented.

The patient's participation in the development of the treatment plan is sought and documented.

Each patient is reassessed to determine current clinical problems, needs, and responses to treatment. Changes in treatment are documented.

(7) Discharge plan. For each patient before discharge, a plan for discharge is designed to provide appropriate continuity of care which meets the following requirements:

The plan for continuing care must describe and facilitate the transfer of the patient and the responsibility for the patient's continuing care to another phase or modality of the program, other programs, agencies, persons or to the patient and the patient's personal support system.

The plan is in accordance with the patient's reassessed needs at the time of transfer.

The plan is developed in collaboration with the patient and, as appropriate and available, with the patient's written verbal permission with family members.

The plan is implemented in a manner acceptable to the patient and the need for confidentiality.

Implementation of the plan includes timely and direct communication with and transfer of information to the other programs, agencies, or persons who will be providing continuing care.

(8) Restrictions and limitations on payment. Medicaid will reimburse for a maximum of 28 treatment days. Payment beyond 28 days is made when documentation indicates that the patient has not reached an exit level.

If an individual has completed all or part of the basic 28-day program, a repeat of the program will be reimbursed with justification. The program will include an aftercare component meeting weekly for at least one year without charge.

b. Eating disorders.

(1) General characteristics. Eating disorders are characterized by gross disturbances in eating behavior. Eating disorders include anorexia nervosa, bulimia, or bulimarexia. Compulsive overeaters are not acceptable for this program.

(2) Diagnostic and treatment staff. Each person who provides diagnostic or treatment services shall be determined to be competent to provide the services by reason of education, training, and experience.

Professional disciplines which must be represented on the diagnostic and treatment staff, either through employment by a facility (full-time or part-time), contract or referral, are a physician (M.D. or D.O.), a licensed psychologist, a counselor with a master's or bachelor's degree and experience, a dietitian with a bachelor's degree and registered dietitian's certificate, and a licensed occupational therapist. The number of staff should be appropriate to the patient load of the facility.

(3) Initial assessment. A comprehensive assessment of the biological, psychological, social, and family orientation of the patient must be conducted. The assessment must include a weight history and a history of the patient's eating and dieting behavior, including binge eating, onset, patterns, and consequences. The assessment shall include the following:

A family history as well as self-assessment regarding chronic dieting, obesity, anorexia, bulimia, drug abuse, alcohol problems, depression, hospitalization for psychiatric reasons, and threatened or attempted suicide.

A history of purging behavior including frequency and history of vomiting, use of laxatives, history and frequency of use of diuretics, history and frequency of use of diet pills, ipecac, or any other weight control measures, and frequency of eating normal meals without vomiting.

A history of exercise behavior, including type, frequency, and duration.

A complete history of current alcohol and other drug use.

Any suicidal thoughts or attempts.

Sexual history, including sexual preference and activity. Sexual interest currently as compared to prior to the eating disorder is needed.

History of experiencing physical or sexual (incest or rape) abuse.

History of other counseling experiences.

Appropriate psychological assessment, including psychological orientation to the above questions.

A medical history, including a physical examination, covering the information listed in subparagraph (4) below.

Appropriate laboratory screening tests based on findings of the history and physical examination and tests for communicable diseases when indicated.

The patient's social support networks, including family and peer relationships.

The patient's educational level, vocational status, and job or school performance history, as appropriate.

The patient's leisure, recreational, or vocational interests and hobbies.

The patient's ability to participate with peers and programs and social activities.

Interview of family members and significant others as available with the patient's written or verbal permission as appropriate.

Legal problems, if applicable.

(4) Admission criteria. In order to be accepted for treatment, the patient shall meet the diagnostic criteria for anorexia nervosa or bulimia as established by the DSM III R (Diagnostic and Statistical Manual, Third Edition, Revised).

In addition to the diagnostic criteria, the need for treatment will be determined by a demonstrable loss of control of eating behaviors and the failure of the patient in recent attempts at voluntary self-control of the problem. Demonstrable impairment, dysfunction, disruption or harm of physical health, emotional health (e.g., significant depression withdrawal, isolation, suicidal ideas), vocational or educational functioning, or interpersonal functioning (e.g., loss of relationships, legal difficulties) shall have occurred.

The need for treatment may be further substantiated by substance abuse, out-of-control spending, incidence of stealing to support habit, or compulsive gambling.

The symptoms shall have been present for at least six months and three of the following criteria must be present:

Medical criteria including endocrine and metabolic factors (e.g., amenorrhea, menstrual irregularities, decreased reflexes, cold intolerance, hypercarotenemia, parotid gland enlargement, lower respiration rate, hair loss, abnormal cholesterol or triglyceride levels).

Other cardiovascular factors including hypotension, hypertension, arrhythmia, ipecac poisoning, fainting, or bradycardia.

Renal considerations including diuretic abuse, dehydration, elevated BUN, renal calculi, edema, or hypokalemia.

Gastrointestinal factors including sore throats, mallery-weiss tears, decreased gastric emptying, constipation, abnormal liver enzymes, rectal bleeding, laxative abuse, or esophagitis.

Hematologic considerations including anemia, leukopenia, or thrombocytopenia.

Ear, nose, and throat factors including headaches or dizziness.

Skin considerations including lanugo or dry skin.

Aspiration pneumonia, a pulmonary factor.

The presence of severe symptoms and complications as evaluated and documented by the medical director may require a period of hospitalization to establish physical or emotional stability.

(5) Plan of treatment. For each patient there is a written comprehensive and individualized description of treatment to be undertaken. The treatment plan is based on problems and needs identified in the assessment and specifies the regular times at which the plan will be reassessed.

The patient's perceptions of needs and, when appropriate and available, the family's perceptions of the patient's needs shall be documented.

The patient's participation in the development of the treatment plans is sought and documented.

Each patient is reassessed to determine current clinical problems, needs, and responses to treatment. Changes in treatment are documented.

(6) Discharge plan. Plans for discharge shall meet the requirements for discharge plans for alcohol and substance abuse patients in subrule 78.31(3), paragraph "a," subparagraph (6).

(7) Restriction and limitations on payment. Medicaid will pay for a maximum of 30 days of a structured outpatient treatment program. Payment beyond 30 days is made when documentation indicates that the patient has not reached an exit level.

Eating disorder programs will include an aftercare component meeting weekly for at least one year without charge.

Family counseling groups held in conjunction with the eating disorders program will be part of the overall treatment charge.

c. Cardiac rehabilitation.

(1) General characteristics. Cardiac rehabilitation programs shall provide a supportive educational environment in which to facilitate behavior change with respect to the accepted cardiac risk factors, initiate prescribed exercise as a mode of facilitating the return of the patient to everyday activities by improving cardiovascular functional capacity and work performance, and promote a long-term commitment to lifestyle changes that could positively affect the course of the cardiovascular disease process.

(2) Treatment staff. Professional disciplines who must be represented on the treatment staff, either by employment by the facility (full-time or part-time), contract or referral, are as follows:

At least one physician responsible for responding to emergencies must be physically present in the hospital when patients are receiving cardiac rehabilitation services. The physician must be trained and certified at least to the level of basic life support.

A medical consultant shall oversee the policies and procedures of the outpatient cardiac rehabilitation area. The director shall meet with the cardiac rehabilitation staff on a regular basis to review exercise prescriptions and any concerns of the team.

A cardiac rehabilitation nurse shall carry out the exercise prescription after assessment of the patient. The nurse shall be able to interpret cardiac dysrhythmia and be able to initiate emergency action if necessary. The nurse shall assess and implement a plan of care for cardiac risk factor modification. The nurse shall have at least one year of experience in a coronary care unit.

A physical therapist shall offer expertise in unusual exercise prescriptions where a patient has an unusual exercise problem.

A dietitian shall assess the dietary needs of persons and appropriately instruct them on their prescribed diets.

A social worker shall provide counseling as appropriate and facilitate a spouse support group. A licensed occupational therapist shall be available as necessary.

(3) Admission criteria. Candidates for the program must be referred by the attending physician. The following conditions are eligible for the program:

Postmyocardial infarction (within three months postdischarge).

Postcardiac surgery (within three months postdischarge).

Poststreptokinase.

Postpercutaneous transluminal angioplasty (within three months postdischarge).

Patient with severe angina being treated medically because of client or doctor preference or inoperable cardiac disease.

(4) Physical environment and equipment. A cardiac rehabilitation unit must be an autonomous physical unit specifically equipped with the necessary telemetry monitoring equipment, exercise equipment, and appropriate equipment and supplies for cardiopulmonary resuscitation (CPR). The exercise equipment must have the capacity to measure the intensity, speed, and length of the exercises. The equipment must be periodically inspected and maintained in accordance with the hospital's preventive maintenance program.

(5) Medical records. Medical records for each cardiac rehabilitation patient shall consist of at least the following:

Referral form.

Physician's orders.

Laboratory reports.

Electrocardiogram reports.

History and physical examination.

Angiogram report, if applicable.

Operative report, if applicable.

Preadmission interview.

Exercise prescription.

Rehabilitation plan, including participant's goals.

Documentation for exercise sessions and progress notes.

Nurse's progress reports.

Discharge instructions.

(6) Discharge plan. The patient will be discharged from the program when the physician, staff, and patient agree that the work level is functional for them and little benefit could be derived from further continuation of the program, dysrhythmia disturbances are resolved, and appropriate cardiovascular response to exercise is accomplished.

(7) Monitoring of services. The program should be monitored by the hospital on a periodic basis using measuring criteria for evaluating cardiac rehabilitation services provided.

(8) Restrictions and limitations. Payment will be made for a maximum of three visits per week for a period of 12 weeks. Payment beyond 12 weeks is made when documentation indicates that the patient has not reached an exit level.

d. Mental health.

(1) General characteristics. To be covered, mental health services must be prescribed by a physician or certified health service provider in psychology, provided under an individualized treatment plan and reasonable and necessary for the diagnosis or treatment of the patient's condition. This means the services must be for the purpose of diagnostic study or the services must reasonably be expected to improve the patient's condition.

(2) Individualized treatment plan. The individualized written plan of treatment shall be established by a physician or certified health service provider in psychology after any needed consultation with appropriate staff members. The plan must state the type, amount, frequency and duration of the services to be furnished and indicate the diagnoses and anticipated goals. (A plan is not required if only a few brief services will be furnished.)

(3) Supervision and evaluation. Services must be supervised and periodically evaluated by a physician, certified health service provider in psychology, or both within the scopes of their respective practices if clinically indicated to determine the extent to which treatment goals are being realized. The evaluation must be based on periodic consultation and conference with therapists and staff. The physician or certified health service provider in psychology must also provide supervision and direction to any therapist involved in the patient's treatment and see the patient periodically to evaluate the course of treatment and to determine the extent to which treatment goals are being realized and whether changes in direction or services are required.

(4) Reasonable expectation of improvement. Services must be for the purpose of diagnostic study or reasonably be expected to improve the patient's condition. The treatment must at a minimum be designed to reduce or control the patient's psychiatric or psychological symptoms so as to prevent relapse or hospitalization and improve or maintain the patient's level of functioning.

It is not necessary that a course of therapy have as its goal restoration of the patient to the level of functioning exhibited prior to the onset of the illness although this may be appropriate for some patients. For many other patients, particularly those with long-term chronic conditions, control of symptoms and maintenance of a functional level to avoid further deterioration or hospitalization is an acceptable expectation of improvement. "Improvement" in this context is measured by comparing the effect of continuing versus discontinuing treatment. Where there is a reasonable expectation that if treatment services were withdrawn, the patient's condition would deteriorate, relapse further, or require hospitalization, this criterion would be met.

(5) Diagnostic and treatment staff. Each person who provides diagnostic or treatment services shall be determined to be competent to provide the services by reason of education, training, and experience. The number of the above staff employed by the facility must be appropriate to the facility's patient load. The staff may be employees of the hospital, on contract, or the service may be provided through referral.

The diagnostic and treatment staff shall consist of a physician, a psychologist, social workers or counselors meeting the requirements for "mental health professionals" as set forth in rule 441—33.1(225C,230A).

(6) Initial assessment. A comprehensive assessment of the biological, psychological, social, and spiritual orientation of the patient must be conducted, which shall include:

A history of the mental health problem, including age of onset, duration, patterns of symptoms, consequences of symptoms, and responses to previous treatment.

A comprehensive clinical history, including the history of physical problems associated with the mental health problem. Appropriate referral for physical examination for determination of any communicable diseases.

Any history of physical abuse.

A systematic mental health examination, with special emphasis on any change in cognitive, social or emotional functioning.

A determination of current and past psychiatric and psychological abnormality.

A determination of any degree of danger to self or others.

The family's history of mental health problems.

The patient's educational level, vocational status, and job performance history.

The patient's social support network, including family and peer relationship.

The patient's perception of the patient's strengths, problem areas, and dependencies.

The patient's leisure, recreational or vocational interests and hobbies.

The patient's ability to participate with peers in programs and social activities.

Interview of family members and significant others, as available, with the patient's written or verbal permission.

Legal problems if applicable.

(7) Covered services. Services covered for the treatment of psychiatric conditions are:

1. Individual and group therapy with physicians, psychologists, social workers, counselors, or psychiatric nurses.

2. Occupational therapy services if the services require the skills of a qualified occupational therapist and must be performed by or under the supervision of a licensed occupational therapist or by an occupational therapy assistant.

3. Drugs and biologicals furnished to outpatients for therapeutic purposes only if they are of the type which cannot be self-administered and are not "covered Part D drugs" as defined by 42 U.S.C. Section 1395w-102(e)(1)-(2) for a "Part D eligible individual" as defined in 42 U.S.C. Section 1395w-101(a)(3)(A), including an individual who is not enrolled in a Part D plan.

4. Activity therapies which are individualized and essential for the treatment of the patient's condition. The treatment plan must clearly justify the need for each particular therapy utilized and explain how it fits into the patient's treatment.

5. Family counseling services are covered only if the primary purpose of the counseling is the treatment of the patient's condition.

6. Partial hospitalization and day treatment services to reduce or control a person's psychiatric or psychological symptoms so as to prevent relapse or hospitalization, improve or maintain the person's level of functioning and minimize regression. These services include all psychiatric services needed by the patient during the day.

Partial hospitalization services means an active treatment program that provides intensive and structured support that assists persons during periods of acute psychiatric or psychological distress or during transition periods, generally following acute inpatient hospitalization episodes.

Service components may include individual and group therapy, reality orientation, stress management and medication management.

Services are provided for a period for four to eight hours per day.

Day treatment services means structured, long-term services designed to assist in restoring, maintaining or increasing levels of functioning, minimizing regression and preventing hospitalization.

Service components include training in independent functioning skills necessary for self-care, emotional stability and psychosocial interactions, and training in medication management.

Services are structured with an emphasis on program variation according to individual need.

Services are provided for a period of three to five hours per day, three or four times per week.

7. Partial hospitalization and day treatment for persons aged 20 or under. Payment to a hospital will be approved for day treatment services for persons aged 20 or under if the hospital is certified by the

department for hospital outpatient mental health services. All conditions for the day treatment program for persons aged 20 or under as outlined in subrule 78.16(7) for community mental health centers shall apply to hospitals. All conditions of the day treatment program for persons aged 20 or under as outlined in subrule 78.16(7) for community mental health centers shall be applicable for the partial hospitalization program for persons aged 20 or under with the exception that the maximum hours shall be 25 hours per week.

(8) Restrictions and limitations on coverage. The following are generally not covered except as indicated:

Activity therapies, group activities, or other services and programs which are primarily recreational or diversional in nature. Outpatient psychiatric day treatment programs that consist entirely of activity therapies are not covered.

Geriatric day-care programs, which provide social and recreational activities to older persons who need some supervision during the day while other family members are away from home. These programs are not covered because they are not considered reasonable and necessary for a diagnosed psychiatric disorder.

Vocational training. While occupational therapy may include vocational and prevocational assessment of training, when the services are related solely to specific employment opportunities, work skills, or work setting, they are not covered.

(9) Frequency and duration of services. There are no specific limits on the length of time that services may be covered. There are many factors that affect the outcome of treatment. Among them are the nature of the illness, prior history, the goals of treatment, and the patient's response. As long as the evidence shows that the patient continues to show improvement in accordance with the individualized treatment plan and the frequency of services is within acceptable norms of medical practice, coverage will be continued.

(10) Documentation requirements. The provider shall develop and maintain sufficient written documentation to support each medical or remedial therapy, service, activity, or session for which billing is made. All outpatient mental health services shall include:

1. The specific services rendered.
2. The date and actual time the services were rendered.
3. Who rendered the services.
4. The setting in which the services were rendered.
5. The amount of time it took to deliver the services.
6. The relationship of the services to the treatment regimen described in the plan of care.
7. Updates describing the patient's progress.

For services that are not specifically included in the patient's treatment plan, a detailed explanation of how the services being billed relate to the treatment regimen and objectives contained in the patient's plan of care and the reason for the departure from the plan shall be given.

e. Pain management.

(1) Approval by commission on accreditation of rehabilitation facilities. In addition to certification by the department, pain management programs must also be approved by the commission on accreditation of rehabilitation facilities (CARF).

(2) General characteristics. A chronic pain management program shall provide coordinated, goal-oriented, interdisciplinary team services to reduce pain, improve quality of life, and decrease dependence on the health care system for persons with pain which interferes with physical, psychosocial, and vocational functioning.

(3) Treatment staff. Each person who provides treatment services shall be determined to be competent to provide the services by reason of education, training, and experience. Professional disciplines which must be represented on the treatment staff, either through employment by the facility (full-time or part-time), contract or referral, are a physician (M.D. or D.O.), a registered nurse, a licensed physical therapist and a licensed clinical psychologist or psychiatrist. The number of staff should be appropriate to the patient load of the facility.

(4) Admission criteria. Candidates for the program shall meet the following guidelines:

The person must have had adequate medical evaluation and treatment in the months preceding admission to the program including an orthopedic or neurological consultation if the problem is back pain or a neurological evaluation if the underlying problem is headaches.

The person must be free of any underlying psychosis or severe neurosis.

The person cannot be toxic on any addictive drugs.

The person must be capable of self-care; including being able to get to meals and to perform activities of daily living.

(5) Plan of treatment. For each patient there is a written comprehensive and individualized description of treatment to be undertaken. The treatment plan is based on the problems and needs identified in the assessment and specifies the times at which the plan will be reassessed.

The patient's perception of needs and, when appropriate and available, the family's perception of the patient's needs shall be documented.

The patient's participation in the development of the treatment plan is sought and documented.

Each patient is reassessed to determine current clinical problems, needs, and responses to treatment. Changes in treatment are documented.

(6) Discharge plan. For each patient before discharge, a plan for discharge is designed to provide appropriate continuity of care which meets the following requirements:

The plan for continuing care must describe and facilitate the transfer of the patient and the responsibility for the patient's continuing care to another phase or modality of the program, other programs, agencies, persons or to the patient and the patient's personal support system.

The plan is in accordance with the patient's reassessed needs at the time of transfer.

The plan is developed in collaboration with the patient and, as appropriate and available, with the patient's written verbal permission with the family members.

The plan is implemented in a manner acceptable to the patient and the need for confidentiality.

Implementation of the plan includes timely and direct communication with and transfer of information to the other programs, agencies, or persons who will be providing continuing care.

(7) Restrictions and limitations on payment. Medicaid will pay for a maximum of three weeks of a structured outpatient treatment program. When documentation indicates that the patient has not reached an exit level, coverage may be extended an extra week.

A repeat of the entire program for any patient will be covered only if a different disease process is causing the pain or a significant change in life situation can be demonstrated.

f. Diabetic education.

(1) Certification by department of public health. In addition to certification by the department for Medicaid, diabetic education programs must also be certified by the department of public health. (See department of public health rules 641—Chapter 9.)

(2) General characteristics. An outpatient diabetes self-management education program shall provide instruction which will enable people with diabetes and their families to understand the diabetes disease process and the daily management of diabetes. People with diabetes must learn to balance their special diet and exercise requirements with drug therapy (insulin or oral agents). They must learn self-care techniques such as monitoring their own blood glucose. And often, they must learn to self-treat insulin reactions, protect feet that are numb and have seriously compromised circulation, and accommodate their regimen to changes in blood glucose because of stress or infections.

(3) Program staff. Each person who provides services shall be determined to be competent to provide the services by reason of education, training and experience. Professional disciplines which must be represented on the staff, either through employment by the facility (full-time or part-time), contract or referral, are a physician (M.D. or D.O.), a registered nurse, a registered dietitian and a licensed pharmacist. The number of staff should be appropriate to the patient load of the facility.

(4) Admission criteria. Candidates for the program shall meet the following guidelines:

The person must have Type I or Type II diabetes.

The person must be referred by the attending physician.

The person shall demonstrate an ability to follow through with self-management.

(5) Health assessment. An individualized and documented assessment of needs shall be developed with the patient's participation. Follow-up assessments, planning and identification of problems shall be provided.

(6) Restrictions and limitations on payment. Medicaid will pay for a diabetic self-management education program. Diabetic education programs will include follow-up assessments at 3 and 12 months without charge. A complete diabetic education program is payable once in the lifetime of a recipient.

g. Pulmonary rehabilitation.

(1) General characteristics. Pulmonary rehabilitation is an individually tailored, multidisciplinary program through which accurate diagnosis, therapy, emotional support, and education stabilizes or reverses both the physio- and psychopathology of pulmonary diseases and attempts to return the patient to the highest possible functional capacity allowed by the pulmonary handicap and overall life situation.

(2) Diagnostic and treatment staff. Each person who provides diagnostic or treatment services shall be determined to be competent to provide the services by reason of education, training, and experience.

Professional disciplines which must be represented by the diagnostic and treatment staff, either through employment by the facility (full-time or part-time), contract, or referral, are a physician (doctor of medicine or osteopathy), a respiratory therapist, a licensed physical therapist, and a registered nurse.

(3) Initial assessment. A comprehensive assessment must occur initially, including:

A diagnostic workup which entails proper identification of the patient's specific respiratory ailment, appropriate pulmonary function studies, a chest radiograph, an electrocardiogram and, when indicated, arterial blood gas measurements at rest and during exercise, sputum analysis and blood theophylline measurements.

Behavioral considerations include emotional screening assessments and treatment or counseling when required, estimating the patient's learning skills and adjusting the program to the patient's ability, assessing family and social support, potential employment skills, employment opportunities, and community resources.

(4) Admission criteria. Criteria include a patient's being diagnosed and symptomatic of chronic obstructive pulmonary disease (COPD), having cardiac stability, social, family, and financial resources, ability to tolerate periods of sitting time; and being a nonsmoker for six months, or if a smoker, willingness to quit and a physician's order to participate anyway.

Factors which would make a person ineligible include acute or chronic illness that may interfere with rehabilitation, any illness or disease state that affects comprehension or retention of information, a strong history of medical noncompliance, unstable cardiac or cardiovascular problems, and orthopedic difficulties that would prohibit exercise.

(5) Plan of treatment. Individualized long- and short-term goals will be developed for each patient. The treatment goals will be based on the problems and needs identified in the assessment and specify the regular times at which the plan will be reassessed.

The patients and their families need to help determine and fully understand the goals, so that they realistically approach the treatment phase.

Patients are reassessed to determine current clinical problems, needs, and responses to treatment. Changes in treatment are documented.

Components of pulmonary rehabilitation to be included are physical therapy and relaxation techniques, exercise conditioning or physical conditioning for those with exercise limitations, respiratory therapy, education, an emphasis on the importance of smoking cessation, and nutritional information.

(6) Discharge plan. Ongoing care will generally be the responsibility of the primary care physician. Periodic reassessment will be conducted to evaluate progress and allow for educational reinforcement.

(7) Restrictions and limitations on payment. Medicaid will pay for a maximum of 25 treatment days. Payment beyond 25 days is made when documentation indicates that the patient has not reached an exit level.

h. Nutritional counseling. Payment will be made for persons aged 20 and under for nutritional counseling provided by a licensed dietitian employed by or under contract with a hospital for a nutritional problem or condition of a degree of severity that nutritional counseling beyond that normally expected

as part of the standard medical management is warranted. For persons eligible for the WIC program, a WIC referral is required. Medical necessity for nutritional counseling services exceeding those available through WIC shall be documented.

78.31(5) *Services rendered by advanced registered nurse practitioners certified in family, pediatric, or psychiatric mental health specialties and employed by a hospital.* Rescinded IAB 10/15/03, effective 12/1/03.

This rule is intended to implement Iowa Code section 249A.4.
[ARC 0065C, IAB 4/4/12, effective 6/1/12]

441—78.32(249A) Area education agencies. Payment will be made for physical therapy, occupational therapy, psychological evaluations and counseling, psychotherapy, speech-language therapy, and audiological, nursing, and vision services provided by an area education agency (AEA). Services shall be provided directly by the AEA or through contractual arrangement with the AEA.

This rule is intended to implement Iowa Code section 249A.4.

441—78.33(249A) Case management services.

78.33(1) Payment will be approved for targeted case management services that are provided pursuant to 441—Chapter 90 to:

- a. Members who are 18 years of age or over and have a primary diagnosis of mental retardation, developmental disabilities, or chronic mental illness as defined in rule 441—90.1(249A).
- b. Members who are under 18 years of age and are receiving services under the HCBS intellectual disability waiver or children's mental health waiver.

78.33(2) Notwithstanding subrule 78.33(1), payment shall not be made for targeted case management services for members who are enrolled in the Iowa Plan for Behavioral Health to receive habilitation pursuant to rule 441—78.27(249A) and are enrolled in an integrated health home as described in rule 441—78.53(249A). Members enrolled in the Iowa Plan for Behavioral Health for habilitation and an integrated health home shall receive care coordination in lieu of case management.

This rule is intended to implement Iowa Code section 249A.4.
[ARC 9403B, IAB 3/9/11, effective 5/1/11; ARC 9588B, IAB 6/29/11, effective 9/1/11; ARC 0848C, IAB 7/24/13, effective 7/1/13; ARC 1051C, IAB 10/2/13, effective 11/6/13]

441—78.34(249A) HCBS ill and handicapped waiver services. Payment will be approved for the following services to members eligible for HCBS ill and handicapped waiver services as established in 441—Chapter 83 and as identified in the member's service plan.

78.34(1) Homemaker services. Homemaker services are those services provided when the member lives alone or when the person who usually performs these functions for the member needs assistance with performing the functions. A unit of service is 15 minutes. Components of the service must be directly related to the care of the member and may include only the following:

- a. Essential shopping: shopping for basic need items such as food, clothing or personal care items, or drugs.
- b. Limited housecleaning: maintenance cleaning such as vacuuming, dusting, scrubbing floors, defrosting refrigerators, cleaning stoves, cleaning medical equipment, washing and mending clothes, washing personal items used by the member, and washing dishes.
- c. Meal preparation: planning and preparing balanced meals.

78.34(2) Home health services. Home health services are personal or direct care services provided to the client which are not payable under Medicaid as set forth in rule 441—78.9(249A). A unit of service is a visit.

- a. Components of the service include, but are not limited to:
 - (1) Observation and reporting of physical or emotional needs.
 - (2) Helping a client with bath, shampoo, or oral hygiene.
 - (3) Helping a client with toileting.
 - (4) Helping a client in and out of bed and with ambulation.
 - (5) Helping a client reestablish activities of daily living.

- (6) Assisting with oral medications ordered by the physician which are ordinarily self-administered.
- (7) Performing incidental household services which are essential to the client's health care at home and are necessary to prevent or postpone institutionalization in order to complete a full unit of service.
- (8) Accompaniment to medical services or transport to and from school.

b. In some cases, a nurse may provide home health services if the health of the client is such that the agency is unable to place an aide in that situation due to limitations by state law or in the event that the agency's Medicare certification requirements prohibit the aide from providing the service. It is not permitted for the convenience of the provider.

c. Skilled nursing care is not covered.

78.34(3) *Adult day care services.* Adult day care services provide an organized program of supportive care in a group environment to persons who need a degree of supervision and assistance on a regular or intermittent basis in a day care center. A unit of service is 15 minutes (up to four units per day), a half day (1.25 to 4 hours per day), a full day (4.25 to 8 hours per day), or an extended day (8.25 to 12 hours per day). Components of the service include health-related care, social services, and other related support services.

78.34(4) *Nursing care services.* Nursing care services are services which are included in the plan of treatment approved by the physician and which are provided by licensed nurses to consumers in the home and community. The services shall be reasonable and necessary to the treatment of an illness or injury and include all nursing tasks recognized by the Iowa board of nursing. A unit of service is a visit.

78.34(5) *Respite care services.* Respite care services are services provided to the member that give temporary relief to the usual caregiver and provide all the necessary care that the usual caregiver would provide during that period. The purpose of respite care is to enable the member to remain in the member's current living situation.

a. Services provided outside the member's home shall not be reimbursable if the living unit where respite is provided is reserved for another person on a temporary leave of absence.

b. Member-to-staff ratios shall be appropriate to the individual needs of the member as determined by the member's interdisciplinary team.

c. A unit of service is 15 minutes.

d. Respite care is not to be provided to members during the hours in which the usual caregiver is employed except when the member is attending a 24-hour residential camp. Respite care shall not be used as a substitute for a child's day care. Respite cannot be provided to a member whose usual caregiver is a consumer-directed attendant care provider for the member.

e. The interdisciplinary team shall determine if the member will receive basic individual respite, specialized respite, or group respite as defined in 441—Chapter 83.

f. A maximum of 14 consecutive days of 24-hour respite care may be reimbursed.

g. Respite services provided for a period exceeding 24 consecutive hours to three or more individuals who require nursing care because of a mental or physical condition must be provided by a health care facility licensed as described in Iowa Code chapter 135C.

h. Respite services shall not be provided simultaneously with other residential, nursing, or home health aide services provided through the medical assistance program.

78.34(6) *Counseling services.* Counseling services are face-to-face mental health services provided to the member and caregiver by a mental health professional as defined in rule 441—24.1(225C) to facilitate home management of the member and prevent institutionalization. Counseling services are nonpsychiatric services necessary for the management of depression, assistance with the grief process, alleviation of psychosocial isolation and support in coping with a disability or illness, including terminal illness. Counseling services may be provided both for the purpose of training the member's family or other caregiver to provide care and for the purpose of helping the member and those caring for the member to adjust to the member's disability or terminal condition. Counseling services may be provided to the member's caregiver only when included in the case plan for the member.

Payment will be made for individual and group counseling. A unit of individual counseling for the waiver member or the waiver member and the member's caregiver is 15 minutes. A unit of group counseling is 15 minutes. Payment for group counseling is based on the group rate divided by six, or, if

the number of persons who comprise the group exceeds six, the actual number of persons who comprise the group.

78.34(7) Consumer-directed attendant care service. Consumer-directed attendant care services are service activities performed by a person to help a member with self-care tasks which the member would typically do independently if the member were otherwise able. Covered service activities are limited to the nonskilled activities listed in paragraph 78.34(7)“f” and the skilled activities listed in paragraph 78.34(7)“g.” Covered service activities must be essential to the health, safety, and welfare of the member. Services may be provided in the absence of a parent or guardian if the parent or guardian has given advance direction for the service provision.

a. Service planning.

(1) The member, parent, guardian, or attorney in fact under a durable power of attorney for health care shall:

1. Select the individual or agency that will provide the components of the attendant care services.
2. Determine with the selected provider what components of attendant care services the provider shall perform, subject to confirmation by the service worker or case manager that those components are consistent with the assessment and are authorized covered services.

3. Complete, sign, and date Form 470-3372, HCBS Consumer-Directed Attendant Care Agreement, to indicate the frequency, scope, and duration of services (a description of each service component and the time agreed on for that component). The case manager or service worker and provider shall also sign the agreement.

4. Submit the completed agreement to the service worker or case manager. The agreement shall be part of the member’s service plan and shall be kept in the member’s records, in the provider’s records, and in the service worker’s or case manager’s records. Any service component that is not listed in the agreement shall not be payable.

(2) Whenever a legal representative acts as a provider of consumer-directed attendant care as allowed by 441—paragraph 79.9(7)“b,” the following shall apply:

1. The payment rate for the legal representative must be based on the skill level of the legal representative and may not exceed the median statewide reimbursement rate for the service unless the higher rate receives prior approval from the department;

2. The legal representative may not be paid for more than 40 hours of service per week; and

3. A contingency plan must be established in the member’s service plan to ensure service delivery in the event the legal representative is unable to provide services due to illness or other unexpected event.

b. Supervision of skilled services. Skilled consumer-directed attendant care services shall be provided under the supervision of a licensed nurse or licensed therapist working under the direction of a physician. The licensed nurse or therapist shall:

(1) Retain accountability for actions that are delegated.

(2) Ensure appropriate assessment, planning, implementation, and evaluation.

(3) Make on-site supervisory visits every two weeks with the service provider present.

c. Service documentation. The consumer-directed attendant care provider must complete Form 470-4389, Consumer-Directed Attendant Care (CDAC) Service Record, for each day of service. Any service component that is not documented in accordance with rule 441—79.3(249A) shall not be payable.

d. Role of guardian or attorney. If the member has a guardian or attorney in fact under a durable power of attorney for health care:

(1) The service worker’s or case manager’s service plan shall address how consumer-directed attendant care services will be monitored to ensure that the member’s needs are being adequately met. If the guardian or attorney in fact is the service provider, the service plan shall address how the service worker or case manager shall oversee service provision.

(2) The guardian or attorney in fact shall sign the claim form in place of the member, indicating that the service has been provided as presented on the claim.

e. Service units and billing. A unit of service is 15 minutes provided by an individual or agency. Each service shall be billed in whole units.

f. Nonskilled services. Covered nonskilled service activities are limited to help with the following activities:

- (1) Dressing.
- (2) Bathing, shampooing, hygiene, and grooming.
- (3) Access to and from bed or a wheelchair, transferring, ambulation, and mobility in general.
- (4) Toileting, including bowel, bladder, and catheter assistance (emptying the catheter bag, collecting a specimen, and cleaning the external area around the catheter).
- (5) Meal preparation, cooking, and assistance with feeding, not including the cost of meals themselves. Meal preparation and cooking shall be provided only in the member's home.
- (6) Housekeeping, laundry, and shopping essential to the member's health care at home.
- (7) Taking medications ordinarily self-administered, including those ordered by a physician or other qualified health care provider.
- (8) Minor wound care.
- (9) Going to or returning from a place of employment and job-related tasks while the member is on the job site. Transportation for the member and assistance with understanding or performing the essential job functions are not included in consumer-directed attendant care services.
- (10) Tasks, such as financial management and scheduling, that require cognitive or physical assistance.
- (11) Communication essential to the health and welfare of the member, through interpreting and reading services and use of assistive devices for communication.
- (12) Using transportation essential to the health and welfare of the member. The cost of the transportation is not included.

g. Skilled services. Covered skilled service activities are limited to help with the following activities:

- (1) Tube feedings of members unable to eat solid foods.
- (2) Intravenous therapy administered by a registered nurse.
- (3) Parenteral injections required more than once a week.
- (4) Catheterizations, continuing care of indwelling catheters with supervision of irrigations, and changing of Foley catheters when required.
- (5) Respiratory care including inhalation therapy and tracheotomy care or tracheotomy care and ventilator.
- (6) Care of decubiti and other ulcerated areas, noting and reporting to the nurse or therapist.
- (7) Rehabilitation services including, but not limited to, bowel and bladder training, range of motion exercises, ambulation training, restorative nursing services, respiratory care and breathing programs, reality orientation, reminiscing therapy, remotivation, behavior modification, and reteaching of the activities of daily living.
- (8) Colostomy care.
- (9) Care of uncontrolled medical conditions, such as brittle diabetes, and comfort care of terminal conditions.
- (10) Postsurgical nursing care.
- (11) Monitoring medications requiring close supervision because of fluctuating physical or psychological conditions, e.g., antihypertensives, digitalis preparations, mood-altering or psychotropic drugs, or narcotics.
- (12) Preparing and monitoring response to therapeutic diets.
- (13) Recording and reporting of changes in vital signs to the nurse or therapist.

h. Excluded services and costs. Services, activities, costs and time that are not covered as consumer-directed attendant care include the following (not an exclusive list):

- (1) Any activity related to supervising a member. Only direct services are billable.
- (2) Any activity that the member is able to perform.
- (3) Costs of food.
- (4) Costs for the supervision of skilled services by the nurse or therapist. The supervising nurse or therapist may be paid from private insurance, Medicare, or other third-party payment sources, or may

be paid as another Medicaid service, including early and periodic screening, diagnosis and treatment services.

- (5) Exercise that does not require skilled services.
- (6) Parenting or child care for or on behalf of the member.
- (7) Reminders and cueing.
- (8) Services provided simultaneously with any other similar service regardless of funding source, including other waiver services and state supplementary assistance in-home health-related care services.
- (9) Transportation costs.
- (10) Wait times for any activity.

78.34(8) *Interim medical monitoring and treatment services.* Interim medical monitoring and treatment (IMMT) services are monitoring and treatment of a medical nature for children or adults whose medical needs make alternative care unavailable, inadequate, or insufficient. IMMT services are not intended to provide day care but to supplement available resources. Services must be ordered by a physician.

a. Need for service. The member must be currently receiving home health agency services under rule 441—78.9(249A) and require medical assessment, medical monitoring, and regular medical intervention or intervention in a medical emergency during those services. The service worker or case manager must identify the need for IMMT services after evaluating the member's living environment, family and natural supports, ability to perform activities of daily living, and health care needs. The services must be needed:

- (1) To allow the member's usual caregivers to be employed,
- (2) During a search for employment by a usual caregiver,
- (3) To allow for academic or vocational training of a usual caregiver,
- (4) Due to the hospitalization of a usual caregiver for treatment for physical or mental illness, or
- (5) Due to the death of a usual caregiver.

b. Service requirements. Interim medical monitoring and treatment services shall:

- (1) Provide experiences for each member's social, emotional, intellectual, and physical development;
- (2) Include comprehensive developmental care and any special services for a member with special needs; and

(3) Include medical assessment, medical monitoring, and medical intervention as needed on a regular or emergency basis. Medical intervention means the ability to assess the situation and contact the appropriate medical professional, not the direct application of medical care.

c. Interim medical monitoring and treatment services may include supervision while the member is being transported to and from school.

d. Limitations.

- (1) A maximum of 12 hours of service is available per day.
- (2) Covered services do not include a complete nutritional regimen.
- (3) Interim medical monitoring and treatment services may not duplicate any regular Medicaid or waiver services provided under the state plan. Services under the state plan, including home health agency services under rule 441—78.9(249A), must be exhausted before IMMT services are accessed.

(4) Interim medical monitoring and treatment services shall be provided only in the member's home; in a registered child development home; in a licensed child care center, residential care facility, or adult day care facility; or during the time when the member is being transported to and from school.

(5) The member-to-staff ratio shall not be more than six members to one staff person.

(6) The parent or guardian of the member shall be responsible for the usual and customary nonmedical cost of day care during the time in which the member is receiving IMMT services. Medical care necessary for monitoring and treatment is an allowable IMMT cost. If the cost of care goes above the usual and customary cost of day care services due to the member's medical condition, the costs above the usual and customary cost shall be covered as IMMT services.

e. A unit of service is 15 minutes.

78.34(9) Home and vehicle modification. Covered home or vehicle modifications are physical modifications to the member's home or vehicle that directly address the member's medical or remedial need. Covered modifications must be necessary to provide for the health, welfare, or safety of the member and enable the member to function with greater independence in the home or vehicle.

a. Modifications that are necessary or desirable without regard to the member's medical or remedial need and that would be expected to increase the fair market value of the home or vehicle, such as furnaces, fencing, or adding square footage to the residence, are excluded except as specifically included below. Purchasing or leasing of a motorized vehicle is excluded. Home and vehicle repairs are also excluded.

b. Only the following modifications are covered:

- (1) Kitchen counters, sink space, cabinets, special adaptations to refrigerators, stoves, and ovens.
- (2) Bathtubs and toilets to accommodate transfer, special handles and hoses for shower heads, water faucet controls, and accessible showers and sink areas.
- (3) Grab bars and handrails.
- (4) Turnaround space adaptations.
- (5) Ramps, lifts, and door, hall and window widening.
- (6) Fire safety alarm equipment specific for disability.
- (7) Voice-activated, sound-activated, light-activated, motion-activated, and electronic devices directly related to the member's disability.
- (8) Vehicle lifts, driver-specific adaptations, remote-start systems, including such modifications already installed in a vehicle.
- (9) Keyless entry systems.
- (10) Automatic opening device for home or vehicle door.
- (11) Special door and window locks.
- (12) Specialized doorknobs and handles.
- (13) Plexiglas replacement for glass windows.
- (14) Modification of existing stairs to widen, lower, raise or enclose open stairs.
- (15) Motion detectors.
- (16) Low-pile carpeting or slip-resistant flooring.
- (17) Telecommunications device for the deaf.
- (18) Exterior hard-surface pathways.
- (19) New door opening.
- (20) Pocket doors.
- (21) Installation or relocation of controls, outlets, switches.
- (22) Air conditioning and air filtering if medically necessary.
- (23) Heightening of existing garage door opening to accommodate modified van.
- (24) Bath chairs.

c. A unit of service is the completion of needed modifications or adaptations.

d. All modifications and adaptations shall be provided in accordance with applicable federal, state, and local building and vehicle codes.

e. Services shall be performed following prior department approval of the modification as specified in 441—subrule 79.1(17) and a binding contract between the provider and the member.

f. All contracts for home or vehicle modification shall be awarded through competitive bidding. The contract shall include the scope of work to be performed, the time involved, supplies needed, the cost, diagrams of the project whenever applicable, and an assurance that the provider has liability and workers' compensation coverage and the applicable permit and license.

g. Service payment shall be made to the enrolled home or vehicle modification provider. If applicable, payment will be forwarded to the subcontracting agency by the enrolled home or vehicle modification provider following completion of the approved modifications.

(1) Payment of up to \$6,366.64 per year may be made to certified providers upon satisfactory completion of the service.

(2) The case manager or service worker shall encumber a portion of the cost of a modification every month within the monthly dollar cap allowed for the member until the entire cost of the modification is encumbered within a consecutive 12-month period.

h. Services shall be included in the member's service plan and shall exceed the Medicaid state plan services.

78.34(10) *Personal emergency response or portable locator system.*

a. A personal emergency response system is an electronic device that transmits a signal to a central monitoring station to summon assistance in the event of an emergency.

(1) The required components of the system are:

1. An in-home medical communications transceiver.
2. A remote, portable activator.
3. A central monitoring station with backup systems staffed by trained attendants at all times.
4. Current data files at the central monitoring station containing response protocols and personal, medical, and emergency information for each member.

(2) The service shall be identified in the member's service plan.

(3) A unit of service is a one-time installation fee or one month of service.

(4) Maximum units per state fiscal year shall be the initial installation and 12 months of service.

b. A portable locator system is an electronic device that transmits a signal to a monitoring device. The system allows a member to access assistance in the event of an emergency and allows law enforcement or the monitoring system provider to locate a member who is unable to request help or to activate a system independently. The member must be unable to access assistance in an emergency situation due to the member's age or disability.

(1) The required components of the portable locator system are:

1. A portable communications transceiver or transmitter to be worn or carried by the member.
2. Monitoring by the provider at a central location with response protocols and personal, medical, and emergency information for each member as applicable.

(2) The service shall be identified in the member's service plan.

(3) Payable units of service are purchase of equipment, an installation or set-up fee, and monthly fees.

(4) Maximum units per state fiscal year shall be one equipment purchase, one installation or set-up fee, and 12 months of service.

78.34(11) *Home-delivered meals.* Home-delivered meals are meals prepared elsewhere and delivered to a member at the member's residence.

a. Each meal shall ensure the member receives a minimum of one-third of the daily recommended dietary allowance as established by the Food and Nutrition Board of the National Research Council of the National Academy of Sciences. The meal may also be a liquid supplement that meets the minimum one-third standard.

b. When a restaurant provides the home-delivered meal, the member is required to have a nutritional consultation. The nutritional consultation includes contact with the restaurant to explain the dietary needs of the member and what constitutes the minimum one-third daily dietary allowance.

c. A maximum of two meals is allowed per day. A unit of service is a meal.

78.34(12) *Nutritional counseling.* Nutritional counseling services may be provided for a nutritional problem or condition of such a degree of severity that nutritional counseling beyond that normally expected as part of the standard medical management is warranted. A unit of service is 15 minutes.

78.34(13) *Consumer choices option.* The consumer choices option provides a member with a flexible monthly individual budget that is based on the member's service needs. With the individual budget, the member shall have the authority to purchase goods and services to meet the member's assessed needs and may choose to employ providers of services and supports. The services, supports, and items that are purchased with an individual budget must be directly related to a member's assessed need or goal established in the member's service plan. Components of this service are set forth below.

a. Agreement. As a condition of participating in the consumer choices option, a member shall sign Form 470-4289, HCBS Consumer Choices Informed Consent and Risk Agreement, to document that the member has been informed of the responsibilities and risks of electing the consumer choices option.

b. Individual budget amount. A monthly individual budget amount shall be established for each member based on the assessed needs of the member and based on the services and supports authorized in the member's service plan. The member shall be informed of the individual budget amount during the development of the service plan.

(1) Services that may be included in determining the individual budget amount for a member in the HCBS health and disability waiver are:

1. Consumer-directed attendant care (unskilled).
2. Home and vehicle modification.
3. Home-delivered meals.
4. Homemaker service.
5. Basic individual respite care.

(2) The department shall determine an average unit cost for each service listed in subparagraph 78.34(13) "b"(1) based on actual unit costs from the previous fiscal year plus a cost-of-living adjustment.

(3) In aggregate, costs for individual budget services shall not exceed the current costs of waiver program services. In order to maintain cost neutrality, the department shall apply a utilization adjustment factor to the amount of service authorized in the member's service plan before calculating the value of that service to be included in the individual budget amount.

(4) The department shall compute the utilization adjustment factor for each service by dividing the net costs of all claims paid for the service by the total of the authorized costs for that service, using at least 12 consecutive months of aggregate service data. The utilization adjustment factor shall be no lower than 60 percent. The department shall analyze and adjust the utilization adjustment factor at least annually in order to maintain cost neutrality.

(5) Individual budgets for respite services shall be computed based on the average cost for services identified in subparagraph 78.34(13) "b"(2). Respite services are not subject to the utilization adjustment factor in subparagraph 78.34(13) "b"(3).

(6) Anticipated costs for home and vehicle modification are not subject to the average cost in subparagraph 78.34(13) "b"(2) or the utilization adjustment factor in subparagraph 78.34(13) "b"(3). Anticipated costs for home and vehicle modification shall not include the costs of the financial management services or the independent support broker. Before becoming part of the individual budget, all home and vehicle modifications shall be identified in the member's service plan and approved by the case manager or service worker. Costs for home and vehicle modification may be paid to the financial management services provider in a one-time payment.

(7) The individual budget amount may be changed only at the first of the month and shall remain fixed for the entire month.

c. Required service components. To participate in the consumer choices option, a member must hire an independent support broker and must work with a financial management service that is enrolled as a Medicaid provider. Before hiring the independent support broker, the member shall receive the results of the background check conducted pursuant to 441—Chapter 119.

d. Optional service components. A member who elects the consumer choices option may purchase the following goods, services and supports, which shall be provided in the member's home or at an integrated community setting:

(1) Self-directed personal care services. Self-directed personal care services are services or goods that provide a range of assistance in activities of daily living and incidental activities of daily living that help the member remain in the home and community. These services must be identified in the member's service plan developed by the member's case manager or service worker.

(2) Self-directed community supports and employment. Self-directed community supports and employment are services that support the member in developing and maintaining independence and community integration. These services must be identified in the member's service plan developed by the member's case manager or service worker.

(3) Individual-directed goods and services. Individual-directed goods and services are services, equipment, or supplies not otherwise provided through the Medicaid program that address an assessed need or goal identified in the member's service plan. The item or service shall meet the following requirements:

1. Promote opportunities for community living and inclusion.
2. Increase independence or substitute for human assistance, to the extent the expenditures would otherwise be made for that human assistance.
3. Be accommodated within the member's budget without compromising the member's health and safety.

4. Be provided to the member or directed exclusively toward the benefit of the member.
5. Be the least costly to meet the member's needs.
6. Not be available through another source.

e. Development of the individual budget. The independent support broker shall assist the member in developing and implementing the member's individual budget. The individual budget shall include:

- (1) The costs of the financial management service.
- (2) The costs of the independent support broker. The independent support broker may be compensated for up to 6 hours of service for assisting with the implementation of the initial individual budget. The independent support broker shall not be paid for more than 30 hours of service for an individual member during a 12-month period without prior approval by the department.

(3) The costs of any optional service component chosen by the member as described in paragraph 78.34(13) "d." Costs of the following items and services shall not be covered by the individual budget:

1. Child care services.
2. Clothing not related to an assessed medical need.
3. Conference, meeting or similar venue expenses other than the costs of approved services the member needs while attending the conference, meeting or similar venue.
4. Costs associated with shipping items to the member.
5. Experimental and non-FDA-approved medications, therapies, or treatments.
6. Goods or services covered by other Medicaid programs.
7. Home furnishings.
8. Home repairs or home maintenance.
9. Homeopathic treatments.
10. Insurance premiums or copayments.
11. Items purchased on installment payments.
12. Motorized vehicles.
13. Nutritional supplements.
14. Personal entertainment items.
15. Repairs and maintenance of motor vehicles.
16. Room and board, including rent or mortgage payments.
17. School tuition.
18. Service animals.
19. Services covered by third parties or services that are the responsibility of a non-Medicaid program.
20. Sheltered workshop services.
21. Social or recreational purchases not related to an assessed need or goal identified in the member's service plan.
22. Vacation expenses, other than the costs of approved services the member needs while on vacation.

(4) The costs of any approved home or vehicle modification. When authorized, the budget may include an amount allocated for a home or vehicle modification. Before becoming part of the individual budget, all home and vehicle modifications shall be identified in the member's service plan and approved by the case manager or service worker. The authorized amount shall not be used for anything other than the specific modification.

(5) Any amount set aside in a savings plan to reserve funds for the future purchase of self-directed personal care, individual-directed goods and services, or self-directed community supports and services as defined in paragraph 78.34(13)“d.” The savings plan shall meet the requirements in paragraph 78.34(13)“f.”

f. Savings plan. A member savings plan must be in writing and be approved by the department before the start of the savings plan. Amounts allocated to the savings plan must result from efficiencies in meeting identified needs of the member.

(1) The savings plan shall identify:

1. The specific goods, services, supports or supplies to be purchased through the savings plan.
2. The amount of the individual budget allocated each month to the savings plan.
3. The amount of the individual budget allocated each month to meet the member’s identified service needs.

4. How the member’s assessed needs will continue to be met through the individual budget when funds are placed in savings.

(2) With the exception of funds allocated for respite care, the savings plan shall not include funds budgeted for direct services that were not received. The budgeted amount associated with unused direct services other than respite care shall revert to the Medicaid program at the end of each month. Funds from unused respite services may be allocated to the savings plan but shall not be used for anything other than future respite care.

(3) Funds accumulated under a savings plan shall be used only to purchase items that increase independence or substitute for human assistance to the extent that expenditures would otherwise be made for human assistance, including additional goods, supports, services or supplies. The self-directed personal care, individual-directed goods and services, or self-directed community supports and services purchased with funds from a savings plan must:

1. Be used to meet a member’s identified need,
2. Be medically necessary, and
3. Be approved by the member’s case manager or service worker.

(4) All funds allocated to a savings plan that are not expended by December 31 of each year shall revert to the Medicaid program.

(5) The annual reassessment of a member’s needs must take into account the purchases of goods and services that substitute for human assistance. Adjustments shall be made to the services used to determine the individual budget based on the reassessment.

g. Budget authority. The member shall have authority over the individual budget authorized by the department to perform the following tasks:

(1) Contract with entities to provide services and supports as described in this subrule.

(2) Determine the amount to be paid for services. Reimbursement rates shall be consistent with rates paid by others in the community for the same or substantially similar services. Reimbursement rates for the independent support broker and the financial management service are subject to the limits in 441—subrule 79.1(2). The reimbursement rate for a member’s legal representative who provides services to the member as allowed by 441—paragraph 79.9(7)“b” must be based on the skill level of the legal representative and may not exceed the median statewide reimbursement rate for the service unless the higher rate receives prior approval from the department.

(3) Schedule the provision of services. Whenever a member’s legal representative provides services to the member as allowed by 441—paragraph 79.9(7)“b,” the legal representative may not be paid for more than 40 hours of service per week and a contingency plan must be established in the member’s service plan to ensure service delivery in the event the legal representative is unable to provide services due to illness or other unexpected event.

(4) Authorize payment for optional service components identified in the individual budget.

(5) Reallocate funds among services included in the budget. Every purchase of a good or service must be identified and approved in the individual budget before the purchase is made.

h. Delegation of budget authority. The member may delegate responsibility for the individual budget to a representative in addition to the independent support broker.

- (1) The representative must be at least 18 years old.
- (2) The representative shall not be a current provider of service to the member.
- (3) The member shall sign a consent form that designates who the member has chosen as a representative and what responsibilities the representative shall have.

(4) The representative shall not be paid for this service.

i. Employer authority. The member shall have the authority to be the common-law employer of employees providing services and support under the consumer choices option. A common-law employer has the right to direct and control the performance of the services. The member may perform the following functions:

- (1) Recruit employees.
- (2) Select employees from a worker registry.
- (3) Verify employee qualifications.
- (4) Specify additional employee qualifications.
- (5) Determine employee duties.
- (6) Determine employee wages and benefits.
- (7) Schedule employees.
- (8) Train and supervise employees.

j. Employment agreement. Any person employed by the member to provide services under the consumer choices option shall sign an employment agreement with the member that outlines the employee's and member's responsibilities.

k. Responsibilities of the independent support broker. The independent support broker shall perform the following services as directed by the member or the member's representative:

- (1) Assist the member with developing the member's initial and subsequent individual budgets and with making any changes to the individual budget.
- (2) Have monthly contact with the member for the first four months of implementation of the initial individual budget and have quarterly contact thereafter.
- (3) Complete the required employment packet with the financial management service.
- (4) Assist with interviewing potential employees and entities providing services and supports if requested by the member.
- (5) Assist the member with determining whether a potential employee meets the qualifications necessary to perform the job.
- (6) Assist the member with obtaining a signed consent from a potential employee to conduct background checks if requested by the member.
- (7) Assist the member with negotiating with entities providing services and supports if requested by the member.
- (8) Assist the member with contracts and payment methods for services and supports if requested by the member.
- (9) Assist the member with developing an emergency backup plan. The emergency backup plan shall address any health and safety concerns.
- (10) Review expenditure reports from the financial management service to ensure that services and supports in the individual budget are being provided.
- (11) Document in writing on the independent support broker timecard every contact the broker has with the member. Contact documentation shall include information on the extent to which the member's individual budget has addressed the member's needs and the satisfaction of the member.

l. Responsibilities of the financial management service. The financial management service shall perform all of the following services:

- (1) Receive Medicaid funds in an electronic transfer.
- (2) Process and pay invoices for approved goods and services included in the individual budget.
- (3) Enter the individual budget into the Web-based tracking system chosen by the department and enter expenditures as they are paid.

(4) Provide real-time individual budget account balances for the member, the independent support broker, and the department, available at a minimum during normal business hours (9 a.m. to 5 p.m., Monday through Friday).

(5) Conduct criminal background checks on potential employees pursuant to 441—Chapter 119.

(6) Verify for the member an employee's citizenship or alien status.

(7) Assist the member with fiscal and payroll-related responsibilities including, but not limited to:

1. Verifying that hourly wages comply with federal and state labor rules.

2. Collecting and processing timecards.

3. Withholding, filing, and paying federal, state and local income taxes, Medicare and Social Security (FICA) taxes, and federal (FUTA) and state (SUTA) unemployment and disability insurance taxes, as applicable.

4. Computing and processing other withholdings, as applicable.

5. Processing all judgments, garnishments, tax levies, or other withholding on an employee's pay as may be required by federal, state, or local laws.

6. Preparing and issuing employee payroll checks.

7. Preparing and disbursing IRS Forms W-2 and W-3 annually.

8. Processing federal advance earned income tax credit for eligible employees.

9. Refunding over-collected FICA, when appropriate.

10. Refunding over-collected FUTA, when appropriate.

(8) Assist the member in completing required federal, state, and local tax and insurance forms.

(9) Establish and manage documents and files for the member and the member's employees.

(10) Monitor timecards, receipts, and invoices to ensure that they are consistent with the individual budget. Keep records of all timecards and invoices for each member for a total of five years.

(11) Provide to the department, the independent support broker, and the member monthly and quarterly status reports that include a summary of expenditures paid and amount of budget unused.

(12) Establish an accessible customer service system and a method of communication for the member and the independent support broker that includes alternative communication formats.

(13) Establish a customer services complaint reporting system.

(14) Develop a policy and procedures manual that is current with state and federal regulations and update as necessary.

(15) Develop a business continuity plan in the case of emergencies and natural disasters.

(16) Provide to the department an annual independent audit of the financial management service.

(17) Assist in implementing the state's quality management strategy related to the financial management service.

78.34(14) General service standards. All ill and handicapped waiver services must be provided in accordance with the following standards:

a. Reimbursement shall not be available under the waiver for any services that the member can obtain as other nonwaiver Medicaid services or through any other funding source.

b. All services provided under the waiver must be delivered in the least restrictive environment possible and in conformity with the member's service plan.

c. Services must be billed in whole units.

d. For all services with a 15-minute unit of service, the following rounding process will apply:

(1) Add together the minutes spent on all billable activities during a calendar day for a daily total.

(2) For each day, divide the total minutes spent on billable activities by 15 to determine the number of full 15-minute units for that day.

(3) Round the remainder using these guidelines: Round 1 to 7 minutes down to zero units; round 8 to 14 minutes up to one unit.

(4) Add together the number of full units and the number of rounded units to determine the total number of units to bill for that day.

This rule is intended to implement Iowa Code section 249A.4.

[ARC 9045B, IAB 9/8/10, effective 11/1/10; ARC 9403B, IAB 3/9/11, effective 5/1/11 (See Delay note at end of chapter); ARC 9704B, IAB 9/7/11, effective 9/1/11; ARC 9884B, IAB 11/30/11, effective 1/4/12; ARC 0707C, IAB 5/1/13, effective 7/1/13; ARC 0709C, IAB 5/1/13, effective 7/1/13; ARC 0757C, IAB 5/29/13, effective 8/1/13; ARC 0842C, IAB 7/24/13, effective 7/1/13; ARC 1056C, IAB 10/2/13, effective 11/6/13; ARC 1610C, IAB 9/3/14, effective 8/13/14]

441—78.35(249A) Occupational therapist services. Payment will be approved for the same services provided by an occupational therapist that are payable under Title XVIII of the Social Security Act (Medicare).

This rule is intended to implement Iowa Code section 249A.4.

441—78.36(249A) Hospice services.

78.36(1) General characteristics. A hospice is a public agency or private organization or a subdivision of either that is primarily engaged in providing care to terminally ill individuals. A hospice provides palliative and supportive services to meet the physical, psychosocial, social and spiritual needs of a terminally ill individual and the individual's family or other persons caring for the individual regardless of where the individual resides. Hospice services are those services to control pain and provide support to individuals to continue life with as little disruption as possible.

a. Covered services. Covered services shall include, in accordance with Medicare guidelines, the following:

- (1) Nursing care.
- (2) Medical social services.
- (3) Physician services.
- (4) Counseling services provided to the terminally ill individual and the individual's family members or other persons caring for the individual at the individual's place of residence, including bereavement, dietary, and spiritual counseling.
- (5) Short-term inpatient care provided in a participating hospice inpatient unit or a participating hospital or nursing facility that additionally meets the special hospice standards regarding staffing and patient areas for pain control, symptom management and respite purposes.
- (6) Medical appliances and supplies, including drugs and biologicals, as needed for the palliation and management of the individual's terminal illness and related conditions, except for "covered Part D drugs" as defined by 42 U.S.C. Section 1395w-102(e)(1)-(2) for a "Part D eligible individual" as defined in 42 U.S.C. Section 1395w-101(a)(3)(A), including an individual who is not enrolled in a Part D plan.
- (7) Homemaker and home health aide services.
- (8) Physical therapy, occupational therapy and speech-language pathology unless this provision has been waived under the Medicare program for a specific provider.
- (9) Other items or services specified in the resident's plan that would otherwise be paid under the Medicaid program.

Nursing care, medical social services, and counseling are core hospice services and must routinely be provided directly by hospice employees. The hospice may contract with other providers to provide the remaining services. Bereavement counseling, consisting of counseling services provided after the individual's death to the individual's family or other persons caring for the individual, is a required hospice service but is not reimbursable.

b. Noncovered services.

(1) Covered services not related to the terminal illness. In accordance with Medicare guidelines, all medical services related to the terminal illness are the responsibility of the hospice. Services unrelated to the terminal illness are to be billed separately by the respective provider.

(2) Administrative duties performed by the medical director, any hospice-employed physician, or any consulting physician are included in the normal hospice rates. Patient care provided by the medical director, hospice-employed physician, attending physician, or consulting physician is separately reimbursable. Payment to the attending or consulting physician includes other partners in practice.

(3) Hospice care provided by a hospice other than the hospice designated by the individual unless provided under arrangements made by the designated hospice.

(4) AZT (Retrovir) and other curative antiviral drugs targeted at the human immunodeficiency virus for the treatment of AIDS.

78.36(2) *Categories of care.* Hospice care entails the following four categories of daily care. Guidelines for core and other services must be adhered to for all categories of care.

a. Routine home care is care provided in the place of residence that is not continuous.

b. Continuous home care is provided only during a period of crisis when an individual requires continuous care which is primarily nursing care to achieve palliation or management of acute medical symptoms. Nursing care must be provided by either a registered nurse or a licensed practical nurse and a nurse must be providing care for more than half of the period of care. A minimum of eight hours of care per day must be provided during a 24-hour day to qualify as continuous care. Homemaker and aide services may also be provided to supplement the nursing care.

c. Inpatient respite care is provided to the individual only when necessary to relieve the family members or other persons caring for the individual at home. Respite care may be provided only on an occasional basis and may not be reimbursed for more than five consecutive days at a time. Respite care may not be provided when the individual is a resident of a nursing facility.

d. General inpatient care is provided in periods of acute medical crisis when the individual is hospitalized or in a participating hospice inpatient unit or nursing facility for pain control or acute or chronic symptom management.

78.36(3) *Residence in a nursing facility.* For purposes of the Medicaid hospice benefit, a nursing facility can be considered the residence of a beneficiary. When the person does reside in a nursing facility, the requirement that the care of a resident of a nursing facility must be provided under the immediate direction of either the facility or the resident's personal physician does not apply if all of the following conditions are met:

a. The resident is terminally ill.

b. The resident has elected to receive hospice services under the Medicaid program from a Medicaid-enrolled hospice program.

c. The nursing facility and the Medicaid-enrolled hospice program have entered into a written agreement under which the hospice program takes full responsibility for the professional management of the resident's hospice care and the facility agrees to provide room and board to the resident.

78.36(4) *Approval for hospice benefits.* Payment will be approved for hospice services to individuals who are certified as terminally ill, that is, the individuals have a medical prognosis that their life expectancy is six months or less if the illness runs its normal course, and who elect hospice care rather than active treatment for the illness.

a. Physician certification process. The hospice must obtain certification that an individual is terminally ill in accordance with the following procedures:

(1) The hospice may obtain verbal orders to initiate hospice service from the medical director of the hospice or the physician member of the hospice interdisciplinary group and by the individual's attending physician (if the individual has an attending physician). The verbal order shall be noted in the patient's record. The verbal order must be given within two days of the start of care and be followed up in writing no later than eight calendar days after hospice care is initiated. The certification must include the statement that the individual's medical prognosis is that the individual's life expectancy is six months or less if the illness runs its normal course.

(2) When verbal orders are not secured, the hospice must obtain, no later than two calendar days after hospice care is initiated, written certification signed by the medical director of the hospice or the physician member of the hospice interdisciplinary group and by the individual's attending physician (if the individual has an attending physician). The certification must include the statement that the individual's medical prognosis is that the individual's life expectancy is six months or less, if the illness runs its normal course.

(3) Hospice care benefit periods consist of up to two periods of 90 days each and an unlimited number of subsequent 60-day periods as elected by the individual. The medical director or a physician must recertify at the beginning of each benefit period that the individual is terminally ill.

b. Election procedures. Individuals who are dually eligible for Medicare and Medicaid must receive hospice coverage under Medicare.

(1) Election statement. An individual, or individual's representative, elects to receive the hospice benefit by filing an election statement, Form 470-2618, Election of Medicaid Hospice Benefit, with a particular hospice. The hospice may provide the individual with another election form to use provided the form includes the following information:

1. Identification of the hospice that will provide the care.
2. Acknowledgment that the recipient has been given a full understanding of hospice care.
3. Acknowledgment that the recipient waives the right to regular Medicaid benefits, except for payment to the regular physician and treatment for medical conditions unrelated to the terminal illness.
4. Acknowledgment that recipients are not responsible for copayment or other deductibles.
5. The recipient's Medicaid number.
6. The effective date of election.
7. The recipient's signature.

(2) Change of designation. An individual may change the designation of the particular hospice from which the individual elects to receive hospice care one time only.

(3) Effective date. An individual may designate an effective date for the hospice benefit that begins with the first day of the hospice care or any subsequent day of hospice care, but an individual may not designate an effective date that is earlier than the date that the election is made.

(4) Duration of election. The election to receive hospice care will be considered to continue until one of the following occurs:

1. The individual dies.
2. The individual or the individual's representative revokes the election.
3. The individual's situation changes so that the individual no longer qualifies for the hospice benefit.
4. The hospice elects to terminate the recipient's enrollment in accordance with the hospice's established discharge policy.

(5) Revocation. Form 470-2619, Revocation of Medicaid Hospice Benefit, is completed when an individual or the individual's representative revokes the hospice benefit allowed under Medicaid. When an individual revokes the election of Medicaid coverage of hospice care, the individual resumes Medicaid coverage of the benefits waived when hospice care was elected.

This rule is intended to implement Iowa Code section 249A.4.

441—78.37(249A) HCBS elderly waiver services. Payment will be approved for the following services to members eligible for the HCBS elderly waiver services as established in 441—Chapter 83 and as identified in the member's service plan.

78.37(1) Adult day care services. Adult day care services provide an organized program of supportive care in a group environment to persons who need a degree of supervision and assistance on a regular or intermittent basis in a day care center. A unit of service is 15 minutes (up to four units per day), a half day (1.25 to 4 hours per day), a full day (4.25 to 8 hours per day), or an extended day (8.25 to 12 hours per day). Components of the service include health-related care, social services, and other related support services.

78.37(2) Personal emergency response or portable locator system.

a. A personal emergency response system is an electronic device that transmits a signal to a central monitoring station to summon assistance in the event of an emergency.

(1) The necessary components of a system are:

1. An in-home medical communications transceiver.
2. A remote, portable activator.
3. A central monitoring station with backup systems staffed by trained attendants at all times.

4. Current data files at the central monitoring station containing response protocols and personal, medical, and emergency information for each member.

(2) The service shall be identified in the member's service plan.

(3) A unit of service is a one-time installation fee or one month of service.

(4) Maximum units per state fiscal year shall be the initial installation and 12 months of service.

b. A portable locator system is an electronic device that transmits a signal to a monitoring device. The system allows a member to access assistance in the event of an emergency and allows law enforcement or the monitoring system provider to locate a member who is unable to request help or to activate a system independently. The member must be unable to access assistance in an emergency situation due to the member's age or disability.

(1) The required components of the portable locator system are:

1. A portable communications transceiver or transmitter to be worn or carried by the member.

2. Monitoring by the provider at a central location with response protocols and personal, medical, and emergency information for each member as applicable.

(2) The service shall be identified in the member's service plan.

(3) Payable units of service are purchase of equipment, an installation or set-up fee, and monthly fees.

(4) Maximum units per state fiscal year shall be one equipment purchase, one installation or set-up fee, and 12 months of service.

78.37(3) Home health aide services. Home health aide services are personal or direct care services provided to the client which are not payable under Medicaid as set forth in rule 441—78.9(249A). A unit of service is a visit. Components of the service include:

a. Observation and reporting of physical or emotional needs.

b. Helping a client with bath, shampoo, or oral hygiene.

c. Helping a client with toileting.

d. Helping a client in and out of bed and with ambulation.

e. Helping a client reestablish activities of daily living.

f. Assisting with oral medications ordinarily self-administered and ordered by a physician.

g. Performing incidental household services which are essential to the client's health care at home and are necessary to prevent or postpone institutionalization in order to complete a full unit of service.

78.37(4) Homemaker services. Homemaker services are those services provided when the member lives alone or when the person who usually performs these functions for the member needs assistance with performing the functions. A unit of service is 15 minutes. Components of the service must be directly related to the care of the member and may include only the following:

a. Essential shopping: shopping for basic need items such as food, clothing or personal care items, or drugs.

b. Limited housecleaning: maintenance cleaning such as vacuuming, dusting, scrubbing floors, defrosting refrigerators, cleaning stoves, cleaning medical equipment, washing and mending clothes, washing personal items used by the member, and washing dishes.

c. Meal preparation: planning and preparing balanced meals.

78.37(5) Nursing care services. Nursing care services are services provided by licensed agency nurses to clients in the home which are ordered by and included in the plan of treatment established by the physician. The services are reasonable and necessary to the treatment of an illness or injury and include: observation; evaluation; teaching; training; supervision; therapeutic exercise; bowel and bladder care; administration of medications; intravenous, hypodermoclysis, and enteral feedings; skin care; preparation of clinical and progress notes; coordination of services and informing the physician and other personnel of changes in the patient's condition and needs.

A unit of service is one visit. Nursing care service can pay for a maximum of eight nursing visits per month for intermediate level of care persons. There is no limit on the maximum visits for skilled level of care persons.

78.37(6) Respite care services. Respite care services are services provided to the member that give temporary relief to the usual caregiver and provide all the necessary care that the usual caregiver would

provide during that period. The purpose of respite care is to enable the member to remain in the member's current living situation.

a. Services provided outside the member's home shall not be reimbursable if the living unit where respite is provided is reserved for another person on a temporary leave of absence.

b. Member-to-staff ratios shall be appropriate to the individual needs of the member as determined by the member's interdisciplinary team.

c. A unit of service is 15 minutes.

d. Respite care is not to be provided to members during the hours in which the usual caregiver is employed except when the member is attending a 24-hour residential camp. Respite cannot be provided to a member whose usual caregiver is a consumer-directed attendant care provider for the member.

e. The interdisciplinary team shall determine if the member will receive basic individual respite, specialized respite or group respite as defined in 441—Chapter 83.

f. A maximum of 14 consecutive days of 24-hour respite care may be reimbursed.

g. Respite services provided for a period exceeding 24 consecutive hours to three or more individuals who require nursing care because of a mental or physical condition must be provided by a health care facility licensed as described in Iowa Code chapter 135C.

h. Respite services shall not be provided simultaneously with other residential, nursing, or home health aide services provided through the medical assistance program.

78.37(7) *Chore services.* Chore services provide assistance with the household maintenance activities listed in paragraph 78.37(7) "a," as necessary to allow a member to remain in the member's own home safely and independently. A unit of service is 15 minutes.

a. Chore services are limited to the following services:

(1) Window and door maintenance, such as hanging screen windows and doors, replacing windowpanes, and washing windows;

(2) Minor repairs to walls, floors, stairs, railings and handles;

(3) Heavy cleaning which includes cleaning attics or basements to remove fire hazards, moving heavy furniture, extensive wall washing, floor care, painting, and trash removal;

(4) Lawn mowing and removal of snow and ice from sidewalks and driveways.

b. Leaf raking, bush and tree trimming, trash burning, stick removal, and tree removal are not covered services.

78.37(8) *Home-delivered meals.* Home-delivered meals are meals prepared elsewhere and delivered to a member at the member's residence.

a. Each meal shall ensure the member receives a minimum of one-third of the daily recommended dietary allowance as established by the Food and Nutrition Board of the National Research Council of the National Academy of Sciences. The meal may also be a liquid supplement which meets the minimum one-third standard.

b. When a restaurant provides the home-delivered meal, the member is required to have a nutritional consultation. The nutritional consultation includes contact with the restaurant to explain the dietary needs of the member and what constitutes the minimum one-third daily dietary allowance.

c. A maximum of two meals is allowed per day. A unit of service is a meal.

78.37(9) *Home and vehicle modification.* Covered home or vehicle modifications are physical modifications to the member's home or vehicle that directly address the member's medical or remedial need. Covered modifications must be necessary to provide for the health, welfare, or safety of the member and enable the member to function with greater independence in the home or vehicle.

a. Modifications that are necessary or desirable without regard to the member's medical or remedial need and that would be expected to increase the fair market value of the home or vehicle, such as furnaces, fencing, or adding square footage to the residence, are excluded except as specifically included below. Purchasing or leasing of a motorized vehicle is excluded. Home and vehicle repairs are also excluded.

b. Only the following modifications are covered:

(1) Kitchen counters, sink space, cabinets, special adaptations to refrigerators, stoves, and ovens.

(2) Bathtubs and toilets to accommodate transfer, special handles and hoses for shower heads, water faucet controls, and accessible showers and sink areas.

(3) Grab bars and handrails.

(4) Turnaround space adaptations.

(5) Ramps, lifts, and door, hall and window widening.

(6) Fire safety alarm equipment specific for disability.

(7) Voice-activated, sound-activated, light-activated, motion-activated, and electronic devices directly related to the member's disability.

(8) Vehicle lifts, driver-specific adaptations, remote-start systems, including such modifications already installed in a vehicle.

(9) Keyless entry systems.

(10) Automatic opening device for home or vehicle door.

(11) Special door and window locks.

(12) Specialized doorknobs and handles.

(13) Plexiglas replacement for glass windows.

(14) Modification of existing stairs to widen, lower, raise or enclose open stairs.

(15) Motion detectors.

(16) Low-pile carpeting or slip-resistant flooring.

(17) Telecommunications device for the deaf.

(18) Exterior hard-surface pathways.

(19) New door opening.

(20) Pocket doors.

(21) Installation or relocation of controls, outlets, switches.

(22) Air conditioning and air filtering if medically necessary.

(23) Heightening of existing garage door opening to accommodate modified van.

(24) Bath chairs.

c. A unit of service is the completion of needed modifications or adaptations.

d. All modifications and adaptations shall be provided in accordance with applicable federal, state, and local building and vehicle codes.

e. Services shall be performed following prior department approval of the modification as specified in 441—subrule 79.1(17) and a binding contract between the provider and the member.

f. All contracts for home or vehicle modification shall be awarded through competitive bidding. The contract shall include the scope of work to be performed, the time involved, supplies needed, the cost, diagrams of the project whenever applicable, and an assurance that the provider has liability and workers' compensation coverage and the applicable permit and license.

g. Service payment shall be made to the enrolled home or vehicle modification provider. If applicable, payment will be forwarded to the subcontracting agency by the enrolled home or vehicle modification provider following completion of the approved modifications.

h. Services shall be included in the member's service plan and shall exceed the Medicaid state plan services.

78.37(10) *Mental health outreach.* Mental health outreach services are services provided in a recipient's home to identify, evaluate, and provide treatment and psychosocial support. The services can only be provided on the basis of a referral from the consumer's interdisciplinary team established pursuant to 441—subrule 83.22(2). A unit of service is 15 minutes.

78.37(11) *Transportation.* Transportation services may be provided for members to conduct business errands and essential shopping, to receive medical services when not reimbursed through nonemergency medical transportation, and to reduce social isolation. A unit of service is one mile of transportation or one one-way trip.

78.37(12) *Nutritional counseling.* Nutritional counseling services may be provided for a nutritional problem or condition of such a degree of severity that nutritional counseling beyond that normally expected as part of the standard medical management is warranted. A unit of service is 15 minutes.

78.37(13) *Assistive devices.* Assistive devices means practical equipment products to assist persons with activities of daily living and instrumental activities of daily living to allow the person more independence. They include, but are not limited to: long-reach brush, extra long shoehorn, nonslip grippers to pick up and reach items, dressing aids, shampoo rinse tray and inflatable shampoo tray, double-handled cup and sipper lid. A unit is an item.

a. The service shall be included in the member's service plan and shall exceed the services available under the Medicaid state plan.

b. The service shall be provided following prior approval by the Iowa Medicaid enterprise.

c. Payment for most items shall be based on a fee schedule. The amount of the fee shall be determined as directed in 441—subrule 79.1(17).

78.37(14) *Senior companion.* Senior companion services are nonmedical care supervision, oversight, and respite. Companions may assist with such tasks as meal preparation, laundry, shopping and light housekeeping tasks. This service cannot provide hands-on nursing or medical care. A unit of service is 15 minutes.

78.37(15) *Consumer-directed attendant care service.* Consumer-directed attendant care services are service activities performed by a person to help a member with self-care tasks which the member would typically do independently if the member were otherwise able. Covered service activities are limited to the nonskilled activities listed in paragraph 78.37(15)“f” and the skilled activities listed in paragraph 78.37(15)“g.” Covered service activities must be essential to the health, safety, and welfare of the member. Services may be provided in the absence of a parent or guardian if the parent or guardian has given advance direction for the service provision.

a. *Service planning.*

(1) The member, parent, guardian, or attorney in fact under a durable power of attorney for health care shall:

1. Select the individual, agency or assisted living facility that will provide the components of the attendant care services.

2. Determine with the selected provider what components of attendant care services the provider shall perform, subject to confirmation by the service worker or case manager that those components are consistent with the assessment and are authorized covered services.

3. Complete, sign, and date Form 470-3372, HCBS Consumer-Directed Attendant Care Agreement, to indicate the frequency, scope, and duration of services (a description of each service component and the time agreed on for that component). The case manager or service worker and provider shall also sign the agreement.

4. Submit the completed agreement to the service worker or case manager. The agreement shall be part of the member's service plan and shall be kept in the member's records, in the provider's records, and in the service worker's or case manager's records. Any service component that is not listed in the agreement shall not be payable.

(2) Assisted living agreements with Iowa Medicaid members must specify the services to be considered covered under the assisted living occupancy agreement and those CDAC services to be covered under the elderly waiver. The funding stream for each service must be identified.

(3) Whenever a legal representative acts as a provider of consumer-directed attendant care as allowed by 441—paragraph 79.9(7)“b,” the following shall apply:

1. The payment rate for the legal representative must be based on the skill level of the legal representative and may not exceed the median statewide reimbursement rate for the service unless the higher rate receives prior approval from the department;

2. The legal representative may not be paid for more than 40 hours of service per week; and

3. A contingency plan must be established in the member's service plan to ensure service delivery in the event the legal representative is unable to provide services due to illness or other unexpected event.

b. *Supervision of skilled services.* Skilled consumer-directed attendant care services shall be provided under the supervision of a licensed nurse or licensed therapist working under the direction of a physician. The licensed nurse or therapist shall:

(1) Retain accountability for actions that are delegated.

- (2) Ensure appropriate assessment, planning, implementation, and evaluation.
- (3) Make on-site supervisory visits every two weeks with the service provider present.

c. Service documentation. The consumer-directed attendant care individual and agency providers must complete Form 470-4389, Consumer-Directed Attendant Care (CDAC) Service Record, for each day of service. Assisted living facilities may choose to use Form 470-4389 or may devise another system that adheres to the requirements of rule 441—79.3(249A). Any service component that is not documented in accordance with rule 441—79.3(249A) shall not be payable.

d. Role of guardian or attorney. If the member has a guardian or attorney in fact under a durable power of attorney for health care:

(1) The service worker's or case manager's service plan shall address how consumer-directed attendant care services will be monitored to ensure that the member's needs are being adequately met. If the guardian or attorney in fact is the service provider, the service plan shall address how the service worker or case manager shall oversee service provision.

(2) The guardian or attorney in fact shall sign the claim form in place of the member, indicating that the service has been provided as presented on the claim.

e. Service units and billing. A unit of service is 15 minutes provided by an individual, agency or assisted living facility. Each service shall be billed in whole units.

f. Nonskilled services. Covered nonskilled service activities are limited to help with the following activities:

- (1) Dressing.
- (2) Bathing, shampooing, hygiene, and grooming.
- (3) Access to and from bed or a wheelchair, transferring, ambulation, and mobility in general.
- (4) Toileting, including bowel, bladder, and catheter assistance (emptying the catheter bag, collecting a specimen, and cleaning the external area around the catheter).
- (5) Meal preparation, cooking, and assistance with feeding, not including the cost of meals themselves. Meal preparation and cooking shall be provided only in the member's home.
- (6) Housekeeping, laundry, and shopping essential to the member's health care at home.
- (7) Taking medications ordinarily self-administered, including those ordered by a physician or other qualified health care provider.
- (8) Minor wound care.
- (9) Going to or returning from a place of employment and job-related tasks while the member is on the job site. Transportation for the member and assistance with understanding or performing the essential job functions are not included in consumer-directed attendant care services.
- (10) Tasks, such as financial management and scheduling, that require cognitive or physical assistance.
- (11) Communication essential to the health and welfare of the member, through interpreting and reading services and use of assistive devices for communication.
- (12) Using transportation essential to the health and welfare of the member. The cost of the transportation is not included.

g. Skilled services. Covered skilled service activities are limited to help with the following activities:

- (1) Tube feedings of members unable to eat solid foods.
- (2) Intravenous therapy administered by a registered nurse.
- (3) Parenteral injections required more than once a week.
- (4) Catheterizations, continuing care of indwelling catheters with supervision of irrigations, and changing of Foley catheters when required.
- (5) Respiratory care including inhalation therapy and tracheotomy care or tracheotomy care and ventilator.
- (6) Care of decubiti and other ulcerated areas, noting and reporting to the nurse or therapist.
- (7) Rehabilitation services including, but not limited to, bowel and bladder training, range of motion exercises, ambulation training, restorative nursing services, respiratory care and breathing

programs, reality orientation, reminiscing therapy, remotivation, behavior modification, and reteaching of the activities of daily living.

(8) Colostomy care.

(9) Care of uncontrolled medical conditions, such as brittle diabetes, and comfort care of terminal conditions.

(10) Postsurgical nursing care.

(11) Monitoring medications requiring close supervision because of fluctuating physical or psychological conditions, e.g., antihypertensives, digitalis preparations, mood-altering or psychotropic drugs, or narcotics.

(12) Preparing and monitoring response to therapeutic diets.

(13) Recording and reporting of changes in vital signs to the nurse or therapist.

h. Excluded services and costs. Services, activities, costs and time that are not covered as consumer-directed attendant care include the following (not an exclusive list):

(1) Any activity related to supervising a member. Only direct services are billable.

(2) Any activity that the member is able to perform.

(3) Costs of food.

(4) Costs for the supervision of skilled services by the nurse or therapist. The supervising nurse or therapist may be paid from private insurance, Medicare, or other third-party payment sources, or may be paid as another Medicaid service, including early and periodic screening, diagnosis and treatment services.

(5) Exercise that does not require skilled services.

(6) Parenting or child care for or on behalf of the member.

(7) Reminders and cueing.

(8) Services provided simultaneously with any other similar service regardless of funding source, including other waiver services and state supplementary assistance in-home health-related care services.

(9) Transportation costs.

(10) Wait times for any activity.

78.37(16) Consumer choices option. The consumer choices option provides a member with a flexible monthly individual budget that is based on the member's service needs. With the individual budget, the member shall have the authority to purchase goods and services to meet the member's assessed needs and may choose to employ providers of services and supports. The services, supports, and items that are purchased with an individual budget must be directly related to a member's assessed need or goal established in the member's service plan. Components of this service are set forth below.

a. Agreement. As a condition of participating in the consumer choices option, a member shall sign Form 470-4289, HCBS Consumer Choices Informed Consent and Risk Agreement, to document that the member has been informed of the responsibilities and risks of electing the consumer choices option.

b. Individual budget amount. A monthly individual budget amount shall be established for each member based on the assessed needs of the member and on the services and supports authorized in the member's service plan. The member shall be informed of the individual budget amount during the development of the service plan.

(1) Services that may be included in determining the individual budget amount for a member in the HCBS elderly waiver are:

1. Assistive devices.

2. Chore service.

3. Consumer-directed attendant care (unskilled).

4. Home and vehicle modification.

5. Home-delivered meals.

6. Homemaker service.

7. Basic individual respite care.

8. Senior companion.

9. Transportation.

(2) The department shall determine an average unit cost for each service listed in subparagraph 78.37(16) "b"(1) based on actual unit costs from the previous fiscal year plus a cost-of-living adjustment.

(3) In aggregate, costs for individual budget services shall not exceed the current costs of waiver program services. In order to maintain cost neutrality, the department shall apply a utilization adjustment factor to the amount of service authorized in the member's service plan before calculating the value of that service to be included in the individual budget amount.

(4) The department shall compute the utilization adjustment factor for each service by dividing the net costs of all claims paid for the service by the total of the authorized costs for that service, using at least 12 consecutive months of aggregate service data. The utilization adjustment factor shall be no lower than 60 percent. The department shall analyze and adjust the utilization adjustment factor at least annually in order to maintain cost neutrality.

(5) Individual budgets for respite services shall be computed based on the average cost for services identified in subparagraph 78.37(16) "b"(2). Respite services are not subject to the utilization adjustment factor in subparagraph 78.37(16) "b"(3).

(6) Anticipated costs for home and vehicle modification and assistive devices are not subject to the average cost in subparagraph 78.37(16) "b"(2) or the utilization adjustment factor in subparagraph 78.37(16) "b"(3). Anticipated costs for home and vehicle modification and assistive devices shall not include the costs of the financial management services or the independent support broker. Before becoming part of the individual budget, all home and vehicle modifications and assistive devices shall be identified in the member's service plan and approved by the case manager or service worker. Costs for home and vehicle modification and assistive devices may be paid to the financial management services provider in a one-time payment.

(7) The individual budget amount may be changed only at the first of the month and shall remain fixed for the entire month.

c. Required service components. To participate in the consumer choices option, a member must hire an independent support broker and must work with a financial management service that is enrolled as a Medicaid provider. Before hiring the independent support broker, the member shall receive the results of the background check conducted pursuant to 441—Chapter 119.

d. Optional service components. A member who elects the consumer choices option may purchase the following goods, services and supports, which shall be provided in the member's home or at an integrated community setting:

(1) Self-directed personal care services. Self-directed personal care services are services or goods that provide a range of assistance in activities of daily living and incidental activities of daily living that help the member remain in the home and community. These services must be identified in the member's service plan developed by the member's case manager or service worker.

(2) Self-directed community supports and employment. Self-directed community supports and employment are services that support the member in developing and maintaining independence and community integration. These services must be identified in the member's service plan developed by the member's case manager or service worker.

(3) Individual-directed goods and services. Individual-directed goods and services are services, equipment, or supplies not otherwise provided through the Medicaid program that address an assessed need or goal identified in the member's service plan. The item or service shall meet the following requirements:

1. Promote opportunities for community living and inclusion.
2. Increase independence or substitute for human assistance, to the extent the expenditures would otherwise be made for that human assistance.
3. Be accommodated within the member's budget without compromising the member's health and safety.
4. Be provided to the member or directed exclusively toward the benefit of the member.
5. Be the least costly to meet the member's needs.
6. Not be available through another source.

e. Development of the individual budget. The independent support broker shall assist the member in developing and implementing the member's individual budget. The individual budget shall include:

- (1) The costs of the financial management service.
- (2) The costs of the independent support broker. The independent support broker may be compensated for up to 6 hours of service for assisting with the implementation of the initial individual budget. The independent support broker shall not be paid for more than 30 hours of service for an individual member during a 12-month period without prior approval by the department.
- (3) The costs of any optional service component chosen by the member as described in paragraph 78.37(16) "d." Costs of the following items and services shall not be covered by the individual budget:
 1. Child care services.
 2. Clothing not related to an assessed medical need.
 3. Conference, meeting or similar venue expenses other than the costs of approved services the member needs while attending the conference, meeting or similar venue.
 4. Costs associated with shipping items to the member.
 5. Experimental and non-FDA-approved medications, therapies, or treatments.
 6. Goods or services covered by other Medicaid programs.
 7. Home furnishings.
 8. Home repairs or home maintenance.
 9. Homeopathic treatments.
 10. Insurance premiums or copayments.
 11. Items purchased on installment payments.
 12. Motorized vehicles.
 13. Nutritional supplements.
 14. Personal entertainment items.
 15. Repairs and maintenance of motor vehicles.
 16. Room and board, including rent or mortgage payments.
 17. School tuition.
 18. Service animals.
 19. Services covered by third parties or services that are the responsibility of a non-Medicaid program.
 20. Sheltered workshop services.
 21. Social or recreational purchases not related to an assessed need or goal identified in the member's service plan.
 22. Vacation expenses, other than the costs of approved services the member needs while on vacation.
- (4) The costs of any approved home or vehicle modification or assistive device. When authorized, the budget may include an amount allocated for a home or vehicle modification or an assistive device. Before becoming part of the individual budget, all home and vehicle modifications and assistive devices shall be identified in the member's service plan and approved by the case manager or service worker. The authorized amount shall not be used for anything other than the specific modification or device.
- (5) Any amount set aside in a savings plan to reserve funds for the future purchase of self-directed personal care, individual-directed goods and services, or self-directed community supports and services as defined in paragraph 78.37(16) "d." The savings plan shall meet the requirements in paragraph 78.37(16) "f."

f. Savings plan. A member savings plan must be in writing and be approved by the department before the start of the savings plan. Amounts allocated to the savings plan must result from efficiencies in meeting identified needs of the member.

- (1) The savings plan shall identify:
 1. The specific goods, services, supports or supplies to be purchased through the savings plan.
 2. The amount of the individual budget allocated each month to the savings plan.
 3. The amount of the individual budget allocated each month to meet the member's identified service needs.

4. How the member's assessed needs will continue to be met through the individual budget when funds are placed in savings.

(2) With the exception of funds allocated for respite care, the savings plan shall not include funds budgeted for direct services that were not received. The budgeted amount associated with unused direct services other than respite care shall revert to the Medicaid program at the end of each month. Funds from unused respite services may be allocated to the savings plan but shall not be used for anything other than future respite care.

(3) Funds accumulated under a savings plan shall be used only to purchase items that increase independence or substitute for human assistance to the extent that expenditures would otherwise be made for human assistance, including additional goods, supports, services or supplies. The self-directed personal care, individual-directed goods and services, or self-directed community supports and services purchased with funds from a savings plan must:

1. Be used to meet a member's identified need,
2. Be medically necessary, and
3. Be approved by the member's case manager or service worker.

(4) All funds allocated to a savings plan that are not expended by December 31 of each year shall revert to the Medicaid program.

(5) The annual reassessment of a member's needs must take into account the purchases of goods and services that substitute for human assistance. Adjustments shall be made to the services used to determine the individual budget based on the reassessment.

g. Budget authority. The member shall have authority over the individual budget authorized by the department to perform the following tasks:

(1) Contract with entities to provide services and supports as described in this subrule.

(2) Determine the amount to be paid for services. Reimbursement rates shall be consistent with rates paid by others in the community for the same or substantially similar services. Reimbursement rates for the independent support broker and the financial management service are subject to the limits in 441—subrule 79.1(2). The reimbursement rate for a member's legal representative who provides services to the member as allowed by 441—paragraph 79.9(7) "b" must be based on the skill level of the legal representative and may not exceed the median statewide reimbursement rate for the service unless the higher rate receives prior approval from the department.

(3) Schedule the provision of services. Whenever a member's legal representative provides services to the member as allowed by 441—paragraph 79.9(7) "b," the legal representative may not be paid for more than 40 hours of service per week and a contingency plan must be established in the member's service plan to ensure service delivery in the event the legal representative is unable to provide services due to illness or other unexpected event.

(4) Authorize payment for optional service components identified in the individual budget.

(5) Reallocate funds among services included in the budget. Every purchase of a good or service must be identified and approved in the individual budget before the purchase is made.

h. Delegation of budget authority. The member may delegate responsibility for the individual budget to a representative in addition to the independent support broker.

(1) The representative must be at least 18 years old.

(2) The representative shall not be a current provider of service to the member.

(3) The member shall sign a consent form that designates who the member has chosen as a representative and what responsibilities the representative shall have.

(4) The representative shall not be paid for this service.

i. Employer authority. The member shall have the authority to be the common-law employer of employees providing services and support under the consumer choices option. A common-law employer has the right to direct and control the performance of the services. The member may perform the following functions:

(1) Recruit employees.

(2) Select employees from a worker registry.

(3) Verify employee qualifications.

- (4) Specify additional employee qualifications.
- (5) Determine employee duties.
- (6) Determine employee wages and benefits.
- (7) Schedule employees.
- (8) Train and supervise employees.

j. Employment agreement. Any person employed by the member to provide services under the consumer choices option shall sign an employment agreement with the member that outlines the employee's and member's responsibilities.

k. Responsibilities of the independent support broker. The independent support broker shall perform the following services as directed by the member or the member's representative:

- (1) Assist the member with developing the member's initial and subsequent individual budgets and with making any changes to the individual budget.
- (2) Have monthly contact with the member for the first four months of implementation of the initial individual budget and have quarterly contact thereafter.
- (3) Complete the required employment packet with the financial management service.
- (4) Assist with interviewing potential employees and entities providing services and supports if requested by the member.
- (5) Assist the member with determining whether a potential employee meets the qualifications necessary to perform the job.
- (6) Assist the member with obtaining a signed consent from a potential employee to conduct background checks if requested by the member.
- (7) Assist the member with negotiating with entities providing services and supports if requested by the member.
- (8) Assist the member with contracts and payment methods for services and supports if requested by the member.
- (9) Assist the member with developing an emergency backup plan. The emergency backup plan shall address any health and safety concerns.
- (10) Review expenditure reports from the financial management service to ensure that services and supports in the individual budget are being provided.
- (11) Document in writing on the independent support broker timecard every contact the broker has with the member. Contact documentation shall include information on the extent to which the member's individual budget has addressed the member's needs and the satisfaction of the member.

l. Responsibilities of the financial management service. The financial management service shall perform all of the following services:

- (1) Receive Medicaid funds in an electronic transfer.
- (2) Process and pay invoices for approved goods and services included in the individual budget.
- (3) Enter the individual budget into the Web-based tracking system chosen by the department and enter expenditures as they are paid.
- (4) Provide real-time individual budget account balances for the member, the independent support broker, and the department, available at a minimum during normal business hours (9 a.m. to 5 p.m., Monday through Friday).
- (5) Conduct criminal background checks on potential employees pursuant to 441—Chapter 119.
- (6) Verify for the member an employee's citizenship or alien status.
- (7) Assist the member with fiscal and payroll-related responsibilities including, but not limited to:
 1. Verifying that hourly wages comply with federal and state labor rules.
 2. Collecting and processing timecards.
 3. Withholding, filing, and paying federal, state and local income taxes, Medicare and Social Security (FICA) taxes, and federal (FUTA) and state (SUTA) unemployment and disability insurance taxes, as applicable.
 4. Computing and processing other withholdings, as applicable.
 5. Processing all judgments, garnishments, tax levies, or other withholding on an employee's pay as may be required by federal, state, or local laws.

6. Preparing and issuing employee payroll checks.
7. Preparing and disbursing IRS Forms W-2 and W-3 annually.
8. Processing federal advance earned income tax credit for eligible employees.
9. Refunding over-collected FICA, when appropriate.
10. Refunding over-collected FUTA, when appropriate.
- (8) Assist the member in completing required federal, state, and local tax and insurance forms.
- (9) Establish and manage documents and files for the member and the member's employees.
- (10) Monitor timecards, receipts, and invoices to ensure that they are consistent with the individual budget. Keep records of all timecards and invoices for each member for a total of five years.
- (11) Provide to the department, the independent support broker, and the member monthly and quarterly status reports that include a summary of expenditures paid and amount of budget unused.
- (12) Establish an accessible customer service system and a method of communication for the member and the independent support broker that includes alternative communication formats.
- (13) Establish a customer services complaint reporting system.
- (14) Develop a policy and procedures manual that is current with state and federal regulations and update as necessary.
- (15) Develop a business continuity plan in the case of emergencies and natural disasters.
- (16) Provide to the department an annual independent audit of the financial management service.
- (17) Assist in implementing the state's quality management strategy related to the financial management service.

78.37(17) Case management services. Case management services are services that assist Medicaid members who reside in a community setting or are transitioning to a community setting in gaining access to needed medical, social, educational, housing, transportation, vocational, and other appropriate services in order to ensure the health, safety, and welfare of the member. Case management is provided at the direction of the member and the interdisciplinary team established pursuant to 441—subrule 83.22(2).

a. Case management services shall be provided as set forth in rules 441—90.5(249A) and 441—90.8(249A).

b. Case management shall not include the provision of direct services by the case managers.

c. Payment for case management shall not be made until the consumer is enrolled in the waiver. Payment shall be made only for case management services performed on behalf of the consumer during a month when the consumer is enrolled.

78.37(18) Assisted living on-call service. The assisted living on-call service provides staff on call 24 hours per day to meet a member's scheduled, unscheduled, and unpredictable needs in a manner that promotes maximum dignity and independence and provides safety and security. A unit of service is one day. To determine units of service provided, the provider will use census information based on member bed status each day.

78.37(19) General service standards. All elderly waiver services must be provided in accordance with the following standards:

a. Reimbursement shall not be available under the waiver for any services that the member can obtain as other nonwaiver Medicaid services or through any other funding source.

b. All services provided under the waiver must be delivered in the least restrictive environment possible and in conformity with the member's service plan.

c. Services must be billed in whole units.

d. For all services with a 15-minute unit of service, the following rounding process will apply:

(1) Add together the minutes spent on all billable activities during a calendar day for a daily total.

(2) For each day, divide the total minutes spent on billable activities by 15 to determine the number of full 15-minute units for that day.

(3) Round the remainder using these guidelines: Round 1 to 7 minutes down to zero units; round 8 to 14 minutes up to one unit.

(4) Add together the number of full units and the number of rounded units to determine the total number of units to bill for that day.

This rule is intended to implement Iowa Code section 249A.4.

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441—78.38(249A) HCBS AIDS/HIV waiver services. Payment will be approved for the following services to members eligible for the HCBS AIDS/HIV waiver services as established in 441—Chapter 83 and as identified in the member's service plan.

78.38(1) Counseling services. Counseling services are face-to-face mental health services provided to the member and caregiver by a mental health professional as defined in rule 441—24.1(225C) to facilitate home management of the member and prevent institutionalization. Counseling services are nonpsychiatric services necessary for the management of depression, assistance with the grief process, alleviation of psychosocial isolation and support in coping with a disability or illness, including terminal illness. Counseling services may be provided both for the purpose of training the member's family or other caregiver to provide care, and for the purpose of helping the member and those caring for the member to adjust to the member's disability or terminal condition. Counseling services may be provided to the member's caregiver only when included in the case plan for the member.

Payment will be made for individual and group counseling. A unit of individual counseling for the waiver member or the waiver member and the member's caregiver is 15 minutes. A unit of group counseling is 15 minutes. Payment for group counseling is based on the group rate divided by six, or, if the number of persons who comprise the group exceeds six, the actual number of persons who comprise the group.

78.38(2) Home health aide services. Home health aide services are personal or direct care services provided to the client which are not payable under Medicaid as set forth in rule 441—78.9(249A). A unit of service is a visit. Components of the service are:

- a. Observation and reporting of physical or emotional needs.
- b. Helping a client with bath, shampoo, or oral hygiene.
- c. Helping a client with toileting.
- d. Helping a client in and out of bed and with ambulation.
- e. Helping a client reestablish activities of daily living.
- f. Assisting with oral medications ordinarily self-administered and ordered by a physician.
- g. Performing incidental household services which are essential to the client's health care at home and are necessary to prevent or postpone institutionalization in order to complete a full unit of service.

78.38(3) Homemaker services. Homemaker services are those services provided when the member lives alone or when the person who usually performs these functions for the member needs assistance with performing the functions. A unit of service is 15 minutes. Components of the service must be directly related to the care of the member and may include only the following:

- a. Essential shopping: shopping for basic need items such as food, clothing or personal care items, or drugs.
- b. Limited housecleaning: maintenance cleaning such as vacuuming, dusting, scrubbing floors, defrosting refrigerators, cleaning stoves, cleaning medical equipment, washing and mending clothes, washing personal items used by the member, and washing dishes.
- c. Meal preparation: planning and preparing balanced meals.

78.38(4) Nursing care services. Nursing care services are services provided by licensed agency nurses to clients in the home which are ordered by and included in the plan of treatment established by the physician. The services shall be reasonable and necessary to the treatment of an illness or injury and include: observation; evaluation; teaching; training; supervision; therapeutic exercise; bowel and bladder care; administration of medications; intravenous and enteral feedings; skin care; preparation of clinical and progress notes; coordination of services; and informing the physician and other personnel of changes in the patient's conditions and needs. A unit of service is a visit.

78.38(5) *Respite care services.* Respite care services are services provided to the member that give temporary relief to the usual caregiver and provide all the necessary care that the usual caregiver would provide during that period. The purpose of respite care is to enable the member to remain in the member's current living situation.

a. Services provided outside the member's home shall not be reimbursable if the living unit where respite is provided is reserved for another person on a temporary leave of absence.

b. Member-to-staff ratios shall be appropriate to the individual needs of the member as determined by the member's interdisciplinary team.

c. A unit of service is 15 minutes.

d. Respite care is not to be provided to members during the hours in which the usual caregiver is employed except when the member is attending a 24-hour residential camp. Respite cannot be provided to a member whose usual caregiver is a consumer-directed attendant care provider for the member.

e. The interdisciplinary team shall determine if the member will receive basic individual respite, specialized respite or group respite as defined in 441—Chapter 83.

f. A maximum of 14 consecutive days of 24-hour respite care may be reimbursed.

g. Respite services provided for a period exceeding 24 consecutive hours to three or more individuals who require nursing care because of a mental or physical condition must be provided by a health care facility licensed as described in Iowa Code chapter 135C.

h. Respite services shall not be provided simultaneously with other residential, nursing, or home health aide services provided through the medical assistance program.

78.38(6) *Home-delivered meals.* Home-delivered meals are meals prepared elsewhere and delivered to a member at the member's residence.

a. Each meal shall ensure the member receives a minimum of one-third of the daily recommended dietary allowance as established by the Food and Nutrition Board of the National Research Council of the National Academy of Sciences. The meal may also be a liquid supplement which meets the minimum one-third standard.

b. When a restaurant provides the home-delivered meal, the member is required to have a nutritional consultation. The nutritional consultation includes contact with the restaurant to explain the dietary needs of the member and what constitutes the minimum one-third daily dietary allowance.

c. A maximum of two meals is allowed per day. A unit of service is a meal.

78.38(7) *Adult day care services.* Adult day care services provide an organized program of supportive care in a group environment to persons who need a degree of supervision and assistance on a regular or intermittent basis in a day care center. A unit of service is 15 minutes (up to four units per day), a half day (1.25 to 4 hours per day), a full day (4.25 to 8 hours per day), or an extended day (8.25 to 12 hours per day). Components of the service include health-related care, social services, and other related support services.

78.38(8) *Consumer-directed attendant care service.* Consumer-directed attendant care services are service activities performed by a person to help a member with self-care tasks which the member would typically do independently if the member were otherwise able. Covered service activities are limited to the nonskilled activities listed in paragraph 78.38(8) "f" and the skilled activities listed in paragraph 78.38(8) "g." Covered service activities must be essential to the health, safety, and welfare of the member. Services may be provided in the absence of a parent or guardian if the parent or guardian has given advance direction for the service provision.

a. Service planning.

(1) The member, parent, guardian, or attorney in fact under a durable power of attorney for health care shall:

1. Select the individual or agency that will provide the components of the attendant care services.

2. Determine with the selected provider what components of attendant care services the provider shall perform, subject to confirmation by the service worker or case manager that those components are consistent with the assessment and are authorized covered services.

3. Complete, sign, and date Form 470-3372, HCBS Consumer-Directed Attendant Care Agreement, to indicate the frequency, scope, and duration of services (a description of each service

component and the time agreed on for that component). The case manager or service worker and provider shall also sign the agreement.

4. Submit the completed agreement to the service worker or case manager. The agreement shall be part of the member's service plan and shall be kept in the member's records, in the provider's records, and in the service worker's or case manager's records. Any service component that is not listed in the agreement shall not be payable.

(2) Whenever a legal representative acts as a provider of consumer-directed attendant care as allowed by 441—paragraph 79.9(7) “b,” the following shall apply:

1. The payment rate for the legal representative must be based on the skill level of the legal representative and may not exceed the median statewide reimbursement rate for the service unless the higher rate receives prior approval from the department;

2. The legal representative may not be paid for more than 40 hours of service per week; and

3. A contingency plan must be established in the member's service plan to ensure service delivery in the event the legal representative is unable to provide services due to illness or other unexpected event.

b. Supervision of skilled services. Skilled consumer-directed attendant care services shall be provided under the supervision of a licensed nurse or licensed therapist working under the direction of a physician. The licensed nurse or therapist shall:

(1) Retain accountability for actions that are delegated.

(2) Ensure appropriate assessment, planning, implementation, and evaluation.

(3) Make on-site supervisory visits every two weeks with the service provider present.

c. Service documentation. The consumer-directed attendant care provider must complete Form 470-4389, Consumer-Directed Attendant Care (CDAC) Service Record, for each day of service. Any service component that is not documented in accordance with rule 441—79.3(249A) shall not be payable.

d. Role of guardian or attorney. If the member has a guardian or attorney in fact under a durable power of attorney for health care:

(1) The service worker's or case manager's service plan shall address how consumer-directed attendant care services will be monitored to ensure that the member's needs are being adequately met. If the guardian or attorney in fact is the service provider, the service plan shall address how the service worker or case manager shall oversee service provision.

(2) The guardian or attorney in fact shall sign the claim form in place of the member, indicating that the service has been provided as presented on the claim.

e. Service units and billing. A unit of service is 15 minutes provided by an individual or agency. Each service shall be billed in whole units.

f. Nonskilled services. Covered nonskilled service activities are limited to help with the following activities:

(1) Dressing.

(2) Bathing, shampooing, hygiene, and grooming.

(3) Access to and from bed or a wheelchair, transferring, ambulation, and mobility in general.

(4) Toileting, including bowel, bladder, and catheter assistance (emptying the catheter bag, collecting a specimen, and cleaning the external area around the catheter).

(5) Meal preparation, cooking, and assistance with feeding, not including the cost of meals themselves. Meal preparation and cooking shall be provided only in the member's home.

(6) Housekeeping, laundry, and shopping essential to the member's health care at home.

(7) Taking medications ordinarily self-administered, including those ordered by a physician or other qualified health care provider.

(8) Minor wound care.

(9) Going to or returning from a place of employment and job-related tasks while the member is on the job site. Transportation for the member and assistance with understanding or performing the essential job functions are not included in consumer-directed attendant care services.

(10) Tasks, such as financial management and scheduling, that require cognitive or physical assistance.

(11) Communication essential to the health and welfare of the member, through interpreting and reading services and use of assistive devices for communication.

(12) Using transportation essential to the health and welfare of the member. The cost of the transportation is not included.

g. Skilled services. Covered skilled service activities are limited to help with the following activities:

- (1) Tube feedings of members unable to eat solid foods.
- (2) Intravenous therapy administered by a registered nurse.
- (3) Parenteral injections required more than once a week.
- (4) Catheterizations, continuing care of indwelling catheters with supervision of irrigations, and changing of Foley catheters when required.

(5) Respiratory care including inhalation therapy and tracheotomy care or tracheotomy care and ventilator.

(6) Care of decubiti and other ulcerated areas, noting and reporting to the nurse or therapist.

(7) Rehabilitation services including, but not limited to, bowel and bladder training, range of motion exercises, ambulation training, restorative nursing services, respiratory care and breathing programs, reality orientation, reminiscing therapy, remotivation, behavior modification, and reteaching of the activities of daily living.

(8) Colostomy care.

(9) Care of uncontrolled medical conditions, such as brittle diabetes, and comfort care of terminal conditions.

(10) Postsurgical nursing care.

(11) Monitoring medications requiring close supervision because of fluctuating physical or psychological conditions, e.g., antihypertensive, digitalis preparations, mood-altering or psychotropic drugs, or narcotics.

(12) Preparing and monitoring response to therapeutic diets.

(13) Recording and reporting of changes in vital signs to the nurse or therapist.

h. Excluded services and costs. Services, activities, costs and time that are not covered as consumer-directed attendant care include the following (not an exclusive list):

- (1) Any activity related to supervising a member. Only direct services are billable.
- (2) Any activity that the member is able to perform.
- (3) Costs of food.
- (4) Costs for the supervision of skilled services by the nurse or therapist. The supervising nurse or therapist may be paid from private insurance, Medicare, or other third-party payment sources, or may be paid as another Medicaid service, including early and periodic screening, diagnosis and treatment services.

(5) Exercise that does not require skilled services.

(6) Parenting or child care for or on behalf of the member.

(7) Reminders and cueing.

(8) Services provided simultaneously with any other similar service regardless of funding source, including other waiver services and state supplementary assistance in-home health-related care services.

(9) Transportation costs.

(10) Wait times for any activity.

78.38(9) Consumer choices option. The consumer choices option provides a member with a flexible monthly individual budget that is based on the member's service needs. With the individual budget, the member shall have the authority to purchase goods and services to meet the member's assessed needs and may choose to employ providers of services and supports. The services, supports, and items that are purchased with an individual budget must be directly related to a member's assessed need or goal established in the member's service plan. Components of this service are set forth below.

a. Agreement. As a condition of participating in the consumer choices option, a member shall sign Form 470-4289, HCBS Consumer Choices Informed Consent and Risk Agreement, to document that the member has been informed of the responsibilities and risks of electing the consumer choices option.

b. Individual budget amount. A monthly individual budget amount shall be established for each member based on the assessed needs of the member and on the services and supports authorized in the member's service plan. The member shall be informed of the individual budget amount during the development of the service plan.

(1) Services that may be included in determining the individual budget amount for a member in the HCBS AIDS/HIV waiver are:

1. Consumer-directed attendant care (unskilled).
2. Home-delivered meals.
3. Homemaker service.
4. Basic individual respite care.

(2) The department shall determine an average unit cost for each service listed in subparagraph 78.38(9) "b"(1) based on actual unit costs from the previous fiscal year plus a cost-of-living adjustment.

(3) In aggregate, costs for individual budget services shall not exceed the current costs of waiver program services. In order to maintain cost neutrality, the department shall apply a utilization adjustment factor to the amount of service authorized in the member's service plan before calculating the value of that service to be included in the individual budget amount.

(4) The department shall compute the utilization adjustment factor for each service by dividing the net costs of all claims paid for the service by the total of the authorized costs for that service, using at least 12 consecutive months of aggregate service data. The utilization adjustment factor shall be no lower than 60 percent. The department shall analyze and adjust the utilization adjustment factor at least annually in order to maintain cost neutrality.

(5) Individual budgets for respite services shall be computed based on the average cost for services identified in subparagraph 78.38(9) "b"(2). Respite services are not subject to the utilization adjustment factor in subparagraph 78.38(9) "b"(3).

(6) The individual budget amount may be changed only at the first of the month and shall remain fixed for the entire month.

c. Required service components. To participate in the consumer choices option, a member must hire an independent support broker and must work with a financial management service that is enrolled as a Medicaid provider. Before hiring the independent support broker, the member shall receive the results of the background check conducted pursuant to 441—Chapter 119.

d. Optional service components. A member who elects the consumer choices option may purchase the following goods, services and supports, which shall be provided in the member's home or at an integrated community setting:

(1) Self-directed personal care services. Self-directed personal care services are services or goods that provide a range of assistance in activities of daily living and incidental activities of daily living that help the member remain in the home and community. These services must be identified in the member's service plan developed by the member's case manager or service worker.

(2) Self-directed community supports and employment. Self-directed community supports and employment are services that support the member in developing and maintaining independence and community integration. These services must be identified in the member's service plan developed by the member's case manager or service worker.

(3) Individual-directed goods and services. Individual-directed goods and services are services, equipment, or supplies not otherwise provided through the Medicaid program that address an assessed need or goal identified in the member's service plan. The item or service shall meet the following requirements:

1. Promote opportunities for community living and inclusion.
2. Increase independence or substitute for human assistance, to the extent the expenditures would otherwise be made for that human assistance.
3. Be accommodated within the member's budget without compromising the member's health and safety.
4. Be provided to the member or directed exclusively toward the benefit of the member.
5. Be the least costly to meet the member's needs.

6. Not be available through another source.
- e. Development of the individual budget.* The independent support broker shall assist the member in developing and implementing the member's individual budget. The individual budget shall include:
 - (1) The costs of the financial management service.
 - (2) The costs of the independent support broker. The independent support broker may be compensated for up to 6 hours of service for assisting with the implementation of the initial individual budget. The independent support broker shall not be paid for more than 30 hours of service for an individual member during a 12-month period without prior approval by the department.
 - (3) The costs of any optional service component chosen by the member as described in paragraph 78.38(9) "d." Costs of the following items and services shall not be covered by the individual budget:
 1. Child care services.
 2. Clothing not related to an assessed medical need.
 3. Conference, meeting or similar venue expenses other than the costs of approved services the member needs while attending the conference, meeting or similar venue.
 4. Costs associated with shipping items to the member.
 5. Experimental and non-FDA-approved medications, therapies, or treatments.
 6. Goods or services covered by other Medicaid programs.
 7. Home furnishings.
 8. Home repairs or home maintenance.
 9. Homeopathic treatments.
 10. Insurance premiums or copayments.
 11. Items purchased on installment payments.
 12. Motorized vehicles.
 13. Nutritional supplements.
 14. Personal entertainment items.
 15. Repairs and maintenance of motor vehicles.
 16. Room and board, including rent or mortgage payments.
 17. School tuition.
 18. Service animals.
 19. Services covered by third parties or services that are the responsibility of a non-Medicaid program.
 20. Sheltered workshop services.
 21. Social or recreational purchases not related to an assessed need or goal identified in the member's service plan.
 22. Vacation expenses, other than the costs of approved services the member needs while on vacation.
 - (4) The costs of any approved home or vehicle modification. When authorized, the budget may include an amount allocated for a home or vehicle modification. Before becoming part of the individual budget, all home and vehicle modifications shall be identified in the member's service plan and approved by the case manager or service worker. The authorized amount shall not be used for anything other than the specific modification.
 - (5) Any amount set aside in a savings plan to reserve funds for the future purchase of self-directed personal care, individual-directed goods and services, or self-directed community supports and services as defined in paragraph 78.38(9) "d." The savings plan shall meet the requirements in paragraph 78.38(9) "f."
- f. Savings plan.* A member savings plan must be in writing and be approved by the department before the start of the savings plan. Amounts allocated to the savings plan must result from efficiencies in meeting identified needs of the member.
 - (1) The savings plan shall identify:
 1. The specific goods, services, supports or supplies to be purchased through the savings plan.
 2. The amount of the individual budget allocated each month to the savings plan.

3. The amount of the individual budget allocated each month to meet the member's identified service needs.

4. How the member's assessed needs will continue to be met through the individual budget when funds are placed in savings.

(2) With the exception of funds allocated for respite care, the savings plan shall not include funds budgeted for direct services that were not received. The budgeted amount associated with unused direct services other than respite care shall revert to the Medicaid program at the end of each month. Funds from unused respite services may be allocated to the savings plan but shall not be used for anything other than future respite care.

(3) Funds accumulated under a savings plan shall be used only to purchase items that increase independence or substitute for human assistance to the extent that expenditures would otherwise be made for human assistance, including additional goods, supports, services or supplies. The self-directed personal care, individual-directed goods and services, or self-directed community supports and services purchased with funds from a savings plan must:

1. Be used to meet a member's identified need,
2. Be medically necessary, and
3. Be approved by the member's case manager or service worker.

(4) All funds allocated to a savings plan that are not expended by December 31 of each year shall revert to the Medicaid program.

(5) The annual reassessment of a member's needs must take into account the purchases of goods and services that substitute for human assistance. Adjustments shall be made to the services used to determine the individual budget based on the reassessment.

g. Budget authority. The member shall have authority over the individual budget authorized by the department to perform the following tasks:

(1) Contract with entities to provide services and supports as described in this subrule.

(2) Determine the amount to be paid for services. Reimbursement rates shall be consistent with rates paid by others in the community for the same or substantially similar services. Reimbursement rates for the independent support broker and the financial management service are subject to the limits in 441—subrule 79.1(2). The reimbursement rate for a member's legal representative who provides services to the member as allowed by 441—paragraph 79.9(7) "b" must be based on the skill level of the legal representative and may not exceed the median statewide reimbursement rate for the service unless the higher rate receives prior approval from the department.

(3) Schedule the provision of services. Whenever a member's legal representative provides services to the member as allowed by 441—paragraph 79.9(7) "b," the legal representative may not be paid for more than 40 hours of service per week and a contingency plan must be established in the member's service plan to ensure service delivery in the event the legal representative is unable to provide services due to illness or other unexpected event.

(4) Authorize payment for optional service components identified in the individual budget.

(5) Reallocate funds among services included in the budget. Every purchase of a good or service must be identified and approved in the individual budget before the purchase is made.

h. Delegation of budget authority. The member may delegate responsibility for the individual budget to a representative in addition to the independent support broker.

(1) The representative must be at least 18 years old.

(2) The representative shall not be a current provider of service to the member.

(3) The member shall sign a consent form that designates who the member has chosen as a representative and what responsibilities the representative shall have.

(4) The representative shall not be paid for this service.

i. Employer authority. The member shall have the authority to be the common-law employer of employees providing services and support under the consumer choices option. A common-law employer has the right to direct and control the performance of the services. The member may perform the following functions:

(1) Recruit employees.

- (2) Select employees from a worker registry.
- (3) Verify employee qualifications.
- (4) Specify additional employee qualifications.
- (5) Determine employee duties.
- (6) Determine employee wages and benefits.
- (7) Schedule employees.
- (8) Train and supervise employees.

j. Employment agreement. Any person employed by the member to provide services under the consumer choices option shall sign an employment agreement with the member that outlines the employee's and member's responsibilities.

k. Responsibilities of the independent support broker. The independent support broker shall perform the following services as directed by the member or the member's representative:

- (1) Assist the member with developing the member's initial and subsequent individual budgets and with making any changes to the individual budget.
- (2) Have monthly contact with the member for the first four months of implementation of the initial individual budget and have quarterly contact thereafter.
- (3) Complete the required employment packet with the financial management service.
- (4) Assist with interviewing potential employees and entities providing services and supports if requested by the member.
- (5) Assist the member with determining whether a potential employee meets the qualifications necessary to perform the job.
- (6) Assist the member with obtaining a signed consent from a potential employee to conduct background checks if requested by the member.
- (7) Assist the member with negotiating with entities providing services and supports if requested by the member.
- (8) Assist the member with contracts and payment methods for services and supports if requested by the member.
- (9) Assist the member with developing an emergency backup plan. The emergency backup plan shall address any health and safety concerns.
- (10) Review expenditure reports from the financial management service to ensure that services and supports in the individual budget are being provided.
- (11) Document in writing on the independent support broker timecard every contact the broker has with the member. Contact documentation shall include information on the extent to which the member's individual budget has addressed the member's needs and the satisfaction of the member.

l. Responsibilities of the financial management service. The financial management service shall perform all of the following services:

- (1) Receive Medicaid funds in an electronic transfer.
- (2) Process and pay invoices for approved goods and services included in the individual budget.
- (3) Enter the individual budget into the Web-based tracking system chosen by the department and enter expenditures as they are paid.
- (4) Provide real-time individual budget account balances for the member, the independent support broker, and the department, available at a minimum during normal business hours (9 a.m. to 5 p.m., Monday through Friday).
- (5) Conduct criminal background checks on potential employees pursuant to 441—Chapter 119.
- (6) Verify for the member an employee's citizenship or alien status.
- (7) Assist the member with fiscal and payroll-related responsibilities including, but not limited to:
 1. Verifying that hourly wages comply with federal and state labor rules.
 2. Collecting and processing timecards.
 3. Withholding, filing, and paying federal, state and local income taxes, Medicare and Social Security (FICA) taxes, and federal (FUTA) and state (SUTA) unemployment and disability insurance taxes, as applicable.
 4. Computing and processing other withholdings, as applicable.

5. Processing all judgments, garnishments, tax levies, or other withholding on an employee's pay as may be required by federal, state, or local laws.
6. Preparing and issuing employee payroll checks.
7. Preparing and disbursing IRS Forms W-2 and W-3 annually.
8. Processing federal advance earned income tax credit for eligible employees.
9. Refunding over-collected FICA, when appropriate.
10. Refunding over-collected FUTA, when appropriate.
- (8) Assist the member in completing required federal, state, and local tax and insurance forms.
- (9) Establish and manage documents and files for the member and the member's employees.
- (10) Monitor timecards, receipts, and invoices to ensure that they are consistent with the individual budget. Keep records of all timecards and invoices for each member for a total of five years.
- (11) Provide to the department, the independent support broker, and the member monthly and quarterly status reports that include a summary of expenditures paid and amount of budget unused.
- (12) Establish an accessible customer service system and a method of communication for the member and the independent support broker that includes alternative communication formats.
- (13) Establish a customer services complaint reporting system.
- (14) Develop a policy and procedures manual that is current with state and federal regulations and update as necessary.
- (15) Develop a business continuity plan in the case of emergencies and natural disasters.
- (16) Provide to the department an annual independent audit of the financial management service.
- (17) Assist in implementing the state's quality management strategy related to the financial management service.

78.38(10) General service standards. All AIDS/HIV waiver services must be provided in accordance with the following standards:

- a. Reimbursement shall not be available under the waiver for any services that the member can obtain as other nonwaiver Medicaid services or through any other funding source.
- b. All services provided under the waiver must be delivered in the least restrictive environment possible and in conformity with the member's service plan.
- c. Services must be billed in whole units.
- d. For all services with a 15-minute unit of service, the following rounding process will apply:
 - (1) Add together the minutes spent on all billable activities during a calendar day for a daily total.
 - (2) For each day, divide the total minutes spent on billable activities by 15 to determine the number of full 15-minute units for that day.
 - (3) Round the remainder using these guidelines: Round 1 to 7 minutes down to zero units; round 8 to 14 minutes up to one unit.
 - (4) Add together the number of full units and the number of rounded units to determine the total number of units to bill for that day.

This rule is intended to implement Iowa Code section 249A.4.

[ARC 9045B, IAB 9/8/10, effective 11/1/10; ARC 9403B, IAB 3/9/11, effective 5/1/11 (See Delay note at end of chapter); ARC 0707C, IAB 5/1/13, effective 7/1/13; ARC 0709C, IAB 5/1/13, effective 7/1/13; ARC 1610C, IAB 9/3/14, effective 8/13/14]

441—78.39(249A) Federally qualified health centers. Payment shall be made for services as defined in Section 1905(a)(2)(C) of the Social Security Act.

78.39(1) Utilization review. Utilization review shall be conducted of Medicaid members who access more than 24 outpatient visits in any 12-month period from physicians, advanced registered nurse practitioners, federally qualified health centers, other clinics, and emergency rooms. Refer to rule 441—76.9(249A) for further information concerning the member lock-in program.

78.39(2) Risk assessment. Risk assessment, using Form 470-2942, Medicaid Prenatal Risk Assessment, shall be completed at the initial visit during a Medicaid member's pregnancy.

- a. If the risk assessment reflects a low-risk pregnancy, the assessment shall be completed again at approximately the twenty-eighth week of pregnancy.

b. If the risk assessment reflects a high-risk pregnancy, referral shall be made for enhanced services. (See description of enhanced services at subrule 78.25(3).)

78.39(3) Vaccines. In order to be paid for the administration of a vaccine covered under the Vaccines for Children (VFC) Program, a federally qualified health center must enroll in the VFC program. Payment for the vaccine will be approved only if the VFC program stock has been depleted.

This rule is intended to implement Iowa Code section 249A.4.
[ARC 0065C, IAB 4/4/12, effective 6/1/12]

441—78.40(249A) Advanced registered nurse practitioners. Payment shall be approved for services provided by advanced registered nurse practitioners within their scope of practice and the limitations of state law, with the exception of services not payable to physicians under rule 441—78.1(249A) or otherwise not payable under any other applicable rule.

78.40(1) Direct payment. Payment shall be made to advanced registered nurse practitioners directly, without regard to whether the advanced registered nurse practitioner is employed by or associated with a physician, hospital, birth center, clinic or other health care provider recognized under state law. An established protocol between a physician and the advanced registered nurse practitioner shall not cause an advanced registered nurse practitioner to be considered auxiliary personnel of a physician, or an employee of a hospital, birth center, or clinic.

78.40(2) Location of service. Payment shall be approved for services rendered in any location in which the advanced registered nurse practitioner is legally authorized to provide services under state law. The nurse practitioner shall have promptly available the necessary equipment and personnel to handle emergencies.

78.40(3) Utilization review. Utilization review shall be conducted of Medicaid members who access more than 24 outpatient visits in any 12-month period from physicians, advanced registered nurse practitioners, other clinics, and emergency rooms. Refer to rule 441—76.9(249A) for further information concerning the member lock-in program.

78.40(4) Vaccines. In order to be paid for the administration of a vaccine covered under the Vaccines for Children (VFC) Program, an advanced registered nurse practitioner must enroll in the VFC program. Payment for the vaccine will be approved only if the VFC program stock has been depleted.

78.40(5) Prenatal risk assessment. Risk assessment, using Form 470-2942, Medicaid Prenatal Risk Assessment, shall be completed at the initial visit during a Medicaid member's pregnancy.

a. If the risk assessment reflects a low-risk pregnancy, the assessment shall be completed again at approximately the twenty-eighth week of pregnancy.

b. If the risk assessment reflects a high-risk pregnancy, referral shall be made for enhanced services. (See description of enhanced services at subrule 78.25(3).)

This rule is intended to implement Iowa Code section 249A.4.
[ARC 0065C, IAB 4/4/12, effective 6/1/12]

441—78.41(249A) HCBS intellectual disability waiver services. Payment will be approved for the following services to members eligible for the HCBS intellectual disability waiver as established in 441—Chapter 83 and as identified in the member's service plan.

78.41(1) Supported community living services. Supported community living services are provided by the provider within the member's home and community, according to the individualized member need as identified in the service plan.

a. Available components of the service are personal and home skills training services, individual advocacy services, community skills training services, personal environment support services, transportation, and treatment services.

(1) Personal and home skills training services are activities which assist a member to develop or maintain skills for self-care, self-directedness, and care of the immediate environment.

(2) Individual advocacy is the act or process of representing the member's rights and interests in order to realize the rights to which the member is entitled and to remove barriers to meeting the member's needs.

(3) Community skills training services are activities which assist a member to develop or maintain skills allowing better participation in the community. Services shall focus on the following areas as they apply to the member being served:

1. Personal management skills training services are activities which assist a member to maintain or develop skills necessary to sustain the member in the physical environment and are essential to the management of the member's personal business and property. This includes self-advocacy skills. Examples of personal management skills are the ability to maintain a household budget, plan and prepare nutritional meals, use community resources such as public transportation and libraries, and select foods at the grocery store.

2. Socialization skills training services are activities which assist a member to develop or maintain skills which include self-awareness and self-control, social responsiveness, community participation, social amenities, and interpersonal skills.

3. Communication skills training services are activities which assist a member to develop or maintain skills including expressive and receptive skills in verbal and nonverbal language and the functional application of acquired reading and writing skills.

(4) Personal and environmental support services are activities and expenditures provided to or on behalf of a member in the areas of personal needs in order to allow the member to function in the least restrictive environment.

(5) Transportation services are activities and expenditures designed to assist the member to travel from one place to another to obtain services or carry out life's activities.

(6) Treatment services are activities designed to assist the member to maintain or improve physiological, emotional and behavioral functioning and to prevent conditions that would present barriers to the member's functioning. Treatment services include physical or physiological treatment and psychotherapeutic treatment.

1. Physiological treatment includes medication regimens designed to prevent, halt, control, relieve, or reverse symptoms or conditions that interfere with the normal functioning of the human body. Physiological treatment shall be provided by or under the direct supervision of a certified or licensed health care professional.

2. Psychotherapeutic treatment means activities provided to assist a member in the identification or modification of beliefs, emotions, attitudes, or behaviors in order to maintain or improve the member's functioning in response to the physical, emotional, and social environment.

b. The supported community living services are intended to provide for the daily living needs of the member and shall be available as needed during any 24-hour period. Activities do not include those associated with vocational services, academics, day care, medical services, Medicaid case management or other case management. Services are individualized supportive services provided in a variety of community-based, integrated settings.

(1) Supported community living services shall be available at a daily rate to members living outside the home of their family, legal representative, or foster family and for whom a provider has primary responsibility for supervision or structure during the month. This service will provide supervision or structure in identified periods when another resource is not available.

(2) Supported community living services shall be available at a 15-minute rate to members for whom a daily rate is not established.

c. Services may be provided to a child or an adult. A maximum of four persons may reside in a living unit.

(1) A member may live within the home of the member's family or legal representative or in another typical community living arrangement.

(2) A member living with the member's family or legal representative is not subject to the maximum of four residents in a living unit.

(3) A member may not live in a licensed medical or health care facility or in a setting that is required to be licensed as a medical or health care facility.

d. A member aged 17 or under living in the home of the member's family, legal representative, or foster family shall receive services based on development of adaptive, behavior, or health skills. Duration of services shall be based on age-appropriateness and individual attention span.

e. Maintenance and room and board costs are not reimbursable.

f. Provider budgets shall reflect all staff-to-member ratios and shall reflect costs associated with members' specific support needs for travel and transportation, consulting, instruction, and environmental modifications and repairs, as determined necessary by the interdisciplinary team for each member. The specific support needs must be identified in the Medicaid case manager's service plan, the total costs shall not exceed \$1570 per member per year, and the provider must maintain records to support the expenditures. A unit of service is:

(1) One full calendar day when a member residing in the living unit receives on-site staff supervision for eight or more hours per day as an average over a calendar month and the member's service plan identifies and reflects the need for this amount of supervision.

(2) Fifteen minutes when subparagraph 78.41(1) "f"(1) does not apply.

g. The maximum number of units available per member is as follows:

(1) 365 daily units per state fiscal year except a leap year when 366 daily units are available.

(2) 20,440 15-minute units are available per state fiscal year except a leap year when 20,496 15-minute units are available.

h. The service shall be identified in the member's service plan.

i. Supported community living services shall not be simultaneously reimbursed with other residential services or with respite, nursing, or home health aide services provided through Medicaid or the HCBS intellectual disability waiver.

78.41(2) Respite care services. Respite care services are services provided to the member that give temporary relief to the usual caregiver and provide all the necessary care that the usual caregiver would provide during that period. The purpose of respite care is to enable the member to remain in the member's current living situation.

a. Services provided outside the member's home shall not be reimbursable if the living unit where respite is provided is reserved for another person on a temporary leave of absence.

b. Member-to-staff ratios shall be appropriate to the individual needs of the member as determined by the member's interdisciplinary team.

c. A unit of service is 15 minutes.

d. Respite care is not to be provided to members during the hours in which the usual caregiver is employed except when the member is attending a 24-hour residential camp. Respite care shall not be used as a substitute for a child's day care. Respite cannot be provided to a member whose usual caregiver is a consumer-directed attendant care provider for the member.

e. The interdisciplinary team shall determine if the member will receive basic individual respite, specialized respite or group respite as defined in 441—Chapter 83.

f. A maximum of 14 consecutive days of 24-hour respite care may be reimbursed.

g. Respite services provided for a period exceeding 24 consecutive hours to three or more individuals who require nursing care because of a mental or physical condition must be provided by a health care facility licensed as described in Iowa Code chapter 135C.

h. Respite services shall not be simultaneously reimbursed with other residential, supported community living, nursing, or home health aide services provided through the medical assistance program.

i. Payment for respite services shall not exceed \$7,262 per the member's waiver year.

78.41(3) Personal emergency response or portable locator system.

a. The personal emergency response system is an electronic device that transmits a signal to a central monitoring station to summon assistance in the event of an emergency.

(1) The necessary components of the system are:

1. An in-home medical communications transceiver.

2. A remote, portable activator.

3. A central monitoring station with backup systems staffed by trained attendants at all times.

4. Current data files at the central monitoring station containing response protocols and personal, medical and emergency information for each member.

(2) The service shall be identified in the member's service plan.

(3) A unit of service is a one-time installation fee or one month of service.

(4) Maximum units per state fiscal year shall be the initial installation and 12 months of service.

b. A portable locator system is an electronic device that transmits a signal to a monitoring device. The system allows a member to access assistance in the event of an emergency and allows law enforcement or the monitoring system provider to locate a member who is unable to request help or to activate a system independently. The member must be unable to access assistance in an emergency situation due to the member's age or disability.

(1) The required components of the portable locator system are:

1. A portable communications transceiver or transmitter to be worn or carried by the member.

2. Monitoring by the provider at a central location with response protocols and personal, medical, and emergency information for each member as applicable.

(2) The service shall be identified in the member's service plan.

(3) Payable units of service are purchase of equipment, an installation or set-up fee, and monthly fees.

(4) Maximum units per state fiscal year shall be one equipment purchase, one installation or set-up fee, and 12 months of service.

78.41(4) Home and vehicle modification. Covered home or vehicle modifications are physical modifications to the member's home or vehicle that directly address the member's medical or remedial need. Covered modifications must be necessary to provide for the health, welfare, or safety of the member and enable the member to function with greater independence in the home or vehicle.

a. Modifications that are necessary or desirable without regard to the member's medical or remedial need and that would be expected to increase the fair market value of the home or vehicle, such as furnaces, fencing, or adding square footage to the residence, are excluded except as specifically included below. Purchasing or leasing of a motorized vehicle is excluded. Home and vehicle repairs are also excluded.

b. Only the following modifications are covered:

(1) Kitchen counters, sink space, cabinets, special adaptations to refrigerators, stoves, and ovens.

(2) Bathtubs and toilets to accommodate transfer, special handles and hoses for shower heads, water faucet controls, and accessible showers and sink areas.

(3) Grab bars and handrails.

(4) Turnaround space adaptations.

(5) Ramps, lifts, and door, hall and window widening.

(6) Fire safety alarm equipment specific for disability.

(7) Voice-activated, sound-activated, light-activated, motion-activated, and electronic devices directly related to the member's disability.

(8) Vehicle lifts, driver-specific adaptations, remote-start systems, including such modifications already installed in a vehicle.

(9) Keyless entry systems.

(10) Automatic opening device for home or vehicle door.

(11) Special door and window locks.

(12) Specialized doorknobs and handles.

(13) Plexiglas replacement for glass windows.

(14) Modification of existing stairs to widen, lower, raise or enclose open stairs.

(15) Motion detectors.

(16) Low-pile carpeting or slip-resistant flooring.

(17) Telecommunications device for the deaf.

(18) Exterior hard-surface pathways.

(19) New door opening.

(20) Pocket doors.

- (21) Installation or relocation of controls, outlets, switches.
- (22) Air conditioning and air filtering if medically necessary.
- (23) Heightening of existing garage door opening to accommodate modified van.
- (24) Bath chairs.

c. A unit of service is the completion of needed modifications or adaptations.

d. All modifications and adaptations shall be provided in accordance with applicable federal, state, and local building and vehicle codes.

e. Services shall be performed following prior department approval of the modification as specified in 441—subrule 79.1(17) and a binding contract between the provider and the member.

f. All contracts for home or vehicle modification shall be awarded through competitive bidding. The contract shall include the scope of work to be performed, the time involved, supplies needed, the cost, diagrams of the project whenever applicable, and an assurance that the provider has liability and workers' compensation coverage and the applicable permit and license.

g. Service payment shall be made to the enrolled home or vehicle modification provider. If applicable, payment will be forwarded to the subcontracting agency by the enrolled home or vehicle modification provider following completion of the approved modifications.

h. Services shall be included in the member's service plan and shall exceed the Medicaid state plan services.

78.41(5) *Nursing services.* Nursing services are individualized in-home medical services provided by licensed nurses. Services shall exceed the Medicaid state plan services and be included in the consumer's individual comprehensive plan.

a. A unit of service is one hour.

b. A maximum of ten units are available per week.

78.41(6) *Home health aide services.* Home health aide services are personal or direct care services provided to the member which are not payable under Medicaid as set forth in rule 441—78.9(249A). Services shall include unskilled medical services and shall exceed those services provided under HCBS intellectual disability waiver supported community living. Instruction, supervision, support or assistance in personal hygiene, bathing, and daily living shall be provided under supported community living.

a. Services shall be included in the member's service plan.

b. A unit is one hour.

c. A maximum of 14 units are available per week.

78.41(7) *Supported employment services.* Supported employment services are individualized services associated with obtaining and maintaining competitive paid employment in the least restrictive environment possible, provided to individuals for whom competitive employment at or above minimum wage is unlikely and who, because of their disability, need intense and ongoing support to perform in a work setting. Individual placements are the preferred service model. Covered services are those listed in paragraphs "a" and "b" that address the disability-related challenges to securing and keeping a job.

a. *Activities to obtain a job.* Covered services directed to obtaining a job must be provided to or on behalf of a member for whom competitive employment is reasonably expected within less than one year. Services must be focused on job placement, not on teaching generalized employment skills or habilitative goals. Three conditions must be met before services are provided. First, the member and the interdisciplinary team described in 441—subrule 83.67(1) must complete the form that Iowa vocational rehabilitation services uses to identify the supported employment services appropriate to meet a person's employment needs. Second, the member's interdisciplinary team must determine that the identified services are necessary. Third, the member's case manager must approve the services. Available components of activities to obtain a job are as follows:

(1) *Job development services.* Job development services are directed toward obtaining competitive employment. A unit of service is a job placement that the member holds for 30 consecutive calendar days or more. Payment is available once the service is authorized in the member's service plan. A member may receive two units of job development services during a 12-month period. The activities provided to the member may include:

1. Job procurement training, including grooming and hygiene, application, résumé development, interviewing skills, follow-up letters, and job search activities.

2. Job retention training, including promptness, coworker relations, transportation skills, disability-related supports, job benefits, and an understanding of employee rights and self-advocacy.

3. Customized job development services specific to the member.

(2) Employer development services. The focus of employer development services is to support employers in hiring and retaining members in their workforce and to communicate expectations of the employers to the interdisciplinary team described in 441—subrule 83.67(1). Employer development services may be provided only to members who are reasonably expected to work for no more than 10 hours per week. A unit of service is one job placement that the member holds for 30 consecutive calendar days or more. Payment for this service may be made only after the member holds the job for 30 days. A member may receive two units of employer development services during a 12-month period if the member is competitively employed for 30 or more consecutive calendar days and the other conditions for service approval are met. The services provided may include:

1. Developing relationships with employers and providing leads for individual members when appropriate.

2. Job analysis for a specific job.

3. Development of a customized training plan identifying job-specific skill requirements, employer expectations, teaching strategies, time frames, and responsibilities.

4. Identifying and arranging reasonable accommodations with the employer.

5. Providing disability awareness and training to the employer when it is deemed necessary.

6. Providing technical assistance to the employer regarding the training progress as identified on the member's customized training plan.

(3) Enhanced job search activities. Enhanced job search activities are associated with obtaining initial employment after job development services have been provided for a minimum of 30 days or with assisting the member in changing jobs due to layoff, termination, or personal choice. The interdisciplinary team must review and update the Iowa vocational rehabilitation services supported employment readiness analysis form to determine if this service remains appropriate for the member's employment goals. A unit of service is 15 minutes. A maximum of 104 units may be provided in a 12-month period. The services provided may include:

1. Job opening identification with the member.

2. Assistance with applying for a job, including completion of applications or interviews.

3. Work site assessment and job accommodation evaluation.

- b. Supports to maintain employment.

(1) Covered services provided to or on behalf of the member associated with maintaining competitive paid employment are the following:

1. Individual work-related behavioral management.

2. Job coaching.

3. On-the-job or work-related crisis intervention.

4. Assisting the member to use skills related to sustaining competitive paid employment, including assistance with communication skills, problem solving, and safety.

5. Consumer-directed attendant care services as defined in subrule 78.41(8).

6. Assistance with time management.

7. Assistance with appropriate grooming.

8. Employment-related supportive contacts.

9. Employment-related transportation between work and home and to or from activities related to employment and disability. Other forms of community transportation (including car pools, coworkers, self or public transportation, families, and volunteers) must be attempted before transportation is provided as a supported employment service.

10. On-site vocational assessment after employment.

11. Employer consultation.

(2) Services for maintaining employment may include services associated with sustaining members in a team of no more than eight individuals with disabilities in a teamwork or “enclave” setting.

(3) A unit of service is 15 minutes.

(4) A maximum of 160 units may be received per week.

c. The following requirements apply to all supported employment services:

(1) Employment-related adaptations required to assist the member within the performance of the member’s job functions shall be provided by the provider as part of the services.

(2) Employment-related transportation between work and home and to or from activities related to employment and disability shall be provided by the provider as part of the services. Other forms of community transportation (car pools, coworkers, self or public transportation, families, volunteers) must be attempted before the service provider provides transportation.

(3) The majority of coworkers at any employment site with more than two employees where members seek, obtain, or maintain employment must be persons without disabilities. In the performance of job duties at any site where members seek, obtain, or maintain employment, the member must have daily contact with other employees or members of the general public who do not have disabilities, unless the absence of daily contact with other employees or the general public is typical for the job as performed by persons without disabilities.

(4) All supported employment services shall provide individualized and ongoing support contacts at intervals necessary to promote successful job retention. Each provider contact shall be documented.

(5) Documentation that services provided are not currently available under a program funded under the Rehabilitation Act of 1973 or Public Law 94-142 shall be maintained in the provider file of each member.

(6) All services shall be identified in the member’s service plan maintained pursuant to rule 441—83.67(249A).

(7) The following services are not covered:

1. Services involved in placing or maintaining members in day activity programs, work activity programs or sheltered workshop programs;

2. Supports for volunteer work or unpaid internships;

3. Tuition for education or vocational training; or

4. Individual advocacy that is not member specific.

(8) Services to maintain employment shall not be provided simultaneously with day activity programs, work activity programs, sheltered workshop programs, other HCBS services, or other Medicaid services. However, services to obtain a job and services to maintain employment may be provided simultaneously for the purpose of job advancement or job change.

78.41(8) *Consumer-directed attendant care service.* Consumer-directed attendant care services are service activities performed by a person to help a member with self-care tasks which the member would typically do independently if the member were otherwise able. Covered service activities are limited to the nonskilled activities listed in paragraph 78.41(8) “f” and the skilled activities listed in paragraph 78.41(8) “g.” Covered service activities must be essential to the health, safety, and welfare of the member. Services may be provided in the absence of a parent or guardian if the parent or guardian has given advance direction for the service provision.

a. *Service planning.*

(1) The member, parent, guardian, or attorney in fact under a durable power of attorney for health care shall:

1. Select the individual or agency that will provide the components of the attendant care services.

2. Determine with the selected provider what components of attendant care services the provider shall perform, subject to confirmation by the service worker or case manager that those components are consistent with the assessment and are authorized covered services.

3. Complete, sign, and date Form 470-3372, HCBS Consumer-Directed Attendant Care Agreement, to indicate the frequency, scope, and duration of services (a description of each service component and the time agreed on for that component). The case manager or service worker and provider shall also sign the agreement.

4. Submit the completed agreement to the service worker or case manager. The agreement shall be part of the member's service plan and shall be kept in the member's records, in the provider's records, and in the service worker's or case manager's records. Any service component that is not listed in the agreement shall not be payable.

(2) Whenever a legal representative acts as a provider of consumer-directed attendant care as allowed by 441—paragraph 79.9(7) “b,” the following shall apply:

1. The payment rate for the legal representative must be based on the skill level of the legal representative and may not exceed the median statewide reimbursement rate for the service unless the higher rate receives prior approval from the department;

2. The legal representative may not be paid for more than 40 hours of service per week; and

3. A contingency plan must be established in the member's service plan to ensure service delivery in the event the legal representative is unable to provide services due to illness or other unexpected event.

b. Supervision of skilled services. Skilled consumer-directed attendant care services shall be provided under the supervision of a licensed nurse or licensed therapist working under the direction of a physician. The licensed nurse or therapist shall:

(1) Retain accountability for actions that are delegated.

(2) Ensure appropriate assessment, planning, implementation, and evaluation.

(3) Make on-site supervisory visits every two weeks with the service provider present.

c. Service documentation. The consumer-directed attendant care provider must complete Form 470-4389, Consumer-Directed Attendant Care (CDAC) Service Record, for each day of service. Any service component that is not documented in accordance with rule 441—79.3(249A) shall not be payable.

d. Role of guardian or attorney. If the member has a guardian or attorney in fact under a durable power of attorney for health care:

(1) The service worker's or case manager's service plan shall address how consumer-directed attendant care services will be monitored to ensure that the member's needs are being adequately met. If the guardian or attorney in fact is the service provider, the service plan shall address how the service worker or case manager shall oversee service provision.

(2) The guardian or attorney in fact shall sign the claim form in place of the member, indicating that the service has been provided as presented on the claim.

e. Service units and billing. A unit of service is 15 minutes provided by an individual or agency. Each service shall be billed in whole units.

f. Nonskilled services. Covered nonskilled service activities are limited to help with the following activities:

(1) Dressing.

(2) Bathing, shampooing, hygiene, and grooming.

(3) Access to and from bed or a wheelchair, transferring, ambulation, and mobility in general.

(4) Toileting, including bowel, bladder, and catheter assistance (emptying the catheter bag, collecting a specimen, and cleaning the external area around the catheter).

(5) Meal preparation, cooking, and assistance with feeding, not including the cost of meals themselves. Meal preparation and cooking shall be provided only in the member's home.

(6) Housekeeping, laundry, and shopping essential to the member's health care at home.

(7) Taking medications ordinarily self-administered, including those ordered by a physician or other qualified health care provider.

(8) Minor wound care.

(9) Going to or returning from a place of employment and job-related tasks while the member is on the job site. Transportation for the member and assistance with understanding or performing the essential job functions are not included in consumer-directed attendant care services.

(10) Tasks, such as financial management and scheduling, that require cognitive or physical assistance.

(11) Communication essential to the health and welfare of the member, through interpreting and reading services and use of assistive devices for communication.

(12) Using transportation essential to the health and welfare of the member. The cost of the transportation is not included.

g. Skilled services. Covered skilled service activities are limited to help with the following activities:

- (1) Tube feedings of members unable to eat solid foods.
- (2) Intravenous therapy administered by a registered nurse.
- (3) Parenteral injections required more than once a week.
- (4) Catheterizations, continuing care of indwelling catheters with supervision of irrigations, and changing of Foley catheters when required.
- (5) Respiratory care including inhalation therapy and tracheotomy care or tracheotomy care and ventilator.
- (6) Care of decubiti and other ulcerated areas, noting and reporting to the nurse or therapist.
- (7) Rehabilitation services including, but not limited to, bowel and bladder training, range of motion exercises, ambulation training, restorative nursing services, respiratory care and breathing programs, reality orientation, reminiscing therapy, remotivation, behavior modification, and reteaching of the activities of daily living.
- (8) Colostomy care.
- (9) Care of uncontrolled medical conditions, such as brittle diabetes, and comfort care of terminal conditions.
- (10) Postsurgical nursing care.
- (11) Monitoring medications requiring close supervision because of fluctuating physical or psychological conditions, e.g., antihypertensives, digitalis preparations, mood-altering or psychotropic drugs, or narcotics.

(12) Preparing and monitoring response to therapeutic diets.

(13) Recording and reporting of changes in vital signs to the nurse or therapist.

h. Excluded services and costs. Services, activities, costs and time that are not covered as consumer-directed attendant care include the following (not an exclusive list):

- (1) Any activity related to supervising a member. Only direct services are billable.
- (2) Any activity that the member is able to perform.
- (3) Costs of food.
- (4) Costs for the supervision of skilled services by the nurse or therapist. The supervising nurse or therapist may be paid from private insurance, Medicare, or other third-party payment sources, or may be paid as another Medicaid service, including early and periodic screening, diagnosis and treatment services.
- (5) Exercise that does not require skilled services.
- (6) Parenting or child care for or on behalf of the member.
- (7) Reminders and cueing.
- (8) Services provided simultaneously with any other similar service regardless of funding source, including other waiver services and state supplementary assistance in-home health-related care services.
- (9) Transportation costs.
- (10) Wait times for any activity.

78.41(9) Interim medical monitoring and treatment services. Interim medical monitoring and treatment (IMMT) services are monitoring and treatment of a medical nature for children or adults whose medical needs make alternative care unavailable, inadequate, or insufficient. IMMT services are not intended to provide day care but to supplement available resources. Services must be ordered by a physician.

a. Need for service. The member must be currently receiving home health agency services under rule 441—78.9(249A) and require medical assessment, medical monitoring, and regular medical intervention or intervention in a medical emergency during those services. The service worker or case manager must identify the need for IMMT services after evaluating the member's living environment, family and natural supports, ability to perform activities of daily living, and health care needs. The services must be needed:

- (1) To allow the member's usual caregivers to be employed,
- (2) During a search for employment by a usual caregiver,
- (3) To allow for academic or vocational training of a usual caregiver,
- (4) Due to the hospitalization of a usual caregiver for treatment for physical or mental illness, or
- (5) Due to the death of a usual caregiver.

b. Service requirements. Interim medical monitoring and treatment services shall:

- (1) Provide experiences for each member's social, emotional, intellectual, and physical development;
- (2) Include comprehensive developmental care and any special services for a member with special needs; and
- (3) Include medical assessment, medical monitoring, and medical intervention as needed on a regular or emergency basis. Medical intervention means the ability to assess the situation and contact the appropriate medical professional, not the direct application of medical care.

c. Interim medical monitoring and treatment services may include supervision while the member is being transported to and from school.

d. Limitations.

- (1) A maximum of 12 hours of service is available per day.
- (2) Covered services do not include a complete nutritional regimen.
- (3) Interim medical monitoring and treatment services may not duplicate any regular Medicaid or waiver services provided under the state plan. Services under the state plan, including home health agency services under rule 441—78.9(249A), must be exhausted before IMMT services are accessed.
- (4) Interim medical monitoring and treatment services shall be provided only in the member's home; in a registered child development home; in a licensed child care center, residential care facility, or adult day care facility; or during the time when the member is being transported to and from school.
- (5) The member-to-staff ratio shall not be more than six members to one staff person.
- (6) The parent or guardian of the member shall be responsible for the usual and customary nonmedical cost of day care during the time in which the member is receiving IMMT services. Medical care necessary for monitoring and treatment is an allowable IMMT cost. If the cost of care goes above the usual and customary cost of day care services due to the member's medical condition, the costs above the usual and customary cost shall be covered as IMMT services.

e. A unit of service is 15 minutes.

78.41(10) Residential-based supported community living services. Residential-based supported community living services are medical or remedial services provided to children under the age of 18 while living outside their home in a residential-based living environment furnished by the residential-based supported community living service provider. The services eliminate barriers to family reunification or develop self-help skills for maximum independence.

a. Allowable service components are the following:

- (1) Daily living skills development. These are services to develop the child's ability to function independently in the community on a daily basis, including training in food preparation, maintenance of living environment, time and money management, personal hygiene, and self-care.
- (2) Social skills development. These are services to develop a child's communication and socialization skills, including interventions to develop a child's ability to solve problems, resolve conflicts, develop appropriate relationships with others, and develop techniques for controlling behavior.
- (3) Family support development. These are services necessary to allow a child to return to the child's family or another less restrictive service environment. These services must include counseling and therapy sessions that involve both the child and the child's family at least 50 percent of the time and that focus on techniques for dealing with the special care needs of the child and interventions needed to alleviate behaviors that are disruptive to the family or other group living unit.
- (4) Counseling and behavior intervention services. These are services to halt, control, or reverse stress and social, emotional, or behavioral problems that threaten or have negatively affected the child's stability. Activities under this service include counseling and behavior intervention with the child, including interventions to ameliorate problem behaviors.

b. Residential-based supported community living services must also address the ordinary daily-living needs of the child, excluding room and board, such as needs for safety and security, social functioning, and other medical care.

c. Residential-based supported community living services do not include services associated with vocational needs, academics, day care, Medicaid case management, other case management, or any other services that the child can otherwise obtain through Medicaid.

d. Room and board costs are not reimbursable as residential-based supported community living services.

e. The scope of service shall be identified in the child's service plan pursuant to 441—paragraph 77.37(23)“d.”

f. Residential-based supported community living services shall not be simultaneously reimbursed with other residential services provided under an HCBS waiver or otherwise provided under the Medicaid program.

g. A unit of service is a day.

h. The maximum number of units of residential-based supported community living services available per child is 365 daily units per state fiscal year, except in a leap year when 366 daily units are available.

78.41(11) *Transportation.* Transportation services may be provided for members to conduct business errands and essential shopping, to receive medical services when not reimbursed through nonemergency medical transportation, to travel to and from work or day programs, and to reduce social isolation. A unit of service is one mile of transportation or one one-way trip. Transportation may not be reimbursed simultaneously with HCBS intellectual disability waiver supported community living service when the transportation costs are included within the supported community living reimbursement rate.

78.41(12) *Adult day care services.* Adult day care services provide an organized program of supportive care in a group environment to persons who need a degree of supervision and assistance on a regular or intermittent basis in a day care center. A unit of service is 15 minutes (up to four units per day), a half day (1.25 to 4 hours per day), a full day (4.25 to 8 hours per day), or an extended day (8.25 to 12 hours per day). Components of the service include health-related care, social services, and other related support services.

78.41(13) *Prevocational services.* Prevocational services are services that are aimed at preparing a member for paid or unpaid employment, but that are not job-task oriented. These services include teaching the member concepts necessary for job readiness, such as following directions, attending to tasks, task completion, problem solving, and safety and mobility training.

a. Prevocational services are intended to have a more generalized result as opposed to vocational training for a specific job or supported employment. Services include activities that are not primarily directed at teaching specific job skills but at more generalized habilitative goals, and are reflected in a habilitative plan that focuses on general habilitative rather than specific employment objectives.

b. Prevocational services do not include:

(1) Services defined in Section 4(a)(4) of the 1975 amendments to the Education of the Handicapped Act (20 U.S.C. 1404(16) and (17)) that are otherwise available to the member through a state or local education agency.

(2) Vocational rehabilitation services that are otherwise available to the member through a program funded under Section 110 of the Rehabilitation Act of 1973 (29 U.S.C. 730).

c. A unit of service is a full day (4.25 to 8 hours) or an hour (for up to 4 hours per day).

78.41(14) *Day habilitation services.*

a. *Scope.* Day habilitation services are services that assist or support the member in developing or maintaining life skills and community integration. Services must enable or enhance the member's intellectual functioning, physical and emotional health and development, language and communication development, cognitive functioning, socialization and community integration, functional skill development, behavior management, responsibility and self-direction, daily living activities, self-advocacy skills, or mobility.

b. Family training option. Day habilitation services may include training families in treatment and support methodologies or in the care and use of equipment. Family training may be provided in the member's home. The unit of service is 15 minutes. The units of services payable are limited to a maximum of 40 units per month.

c. Unit of service. Except as provided in paragraph 78.41(14) "b," the unit of service is 15 minutes (for up to 16 units per day) or a full day (4.25 to 8 hours per day).

d. Exclusions.

(1) Services shall not be provided in the member's home, except as provided in paragraph "b." For this purpose, services provided in a residential care facility where the member lives are not considered to be provided in the member's home.

(2) Services shall not include vocational or prevocational services and shall not involve paid work.

(3) Services shall not duplicate or replace education or related services defined in Public Law 94-142, the Education of the Handicapped Act.

(4) Services shall not be provided simultaneously with other Medicaid-funded services.

78.41(15) Consumer choices option. The consumer choices option provides a member with a flexible monthly individual budget that is based on the member's service needs. With the individual budget, the member shall have the authority to purchase goods and services to meet the member's assessed needs and may choose to employ providers of services and supports. The services, supports, and items that are purchased with an individual budget must be directly related to a member's assessed need or goal established in the member's service plan. Components of this service are set forth below.

a. Agreement. As a condition of participating in the consumer choices option, a member shall sign Form 470-4289, HCBS Consumer Choices Informed Consent and Risk Agreement, to document that the member has been informed of the responsibilities and risks of electing the consumer choices option.

b. Individual budget amount. A monthly individual budget amount shall be established for each member based on the assessed needs of the member and on the services and supports authorized in the member's service plan. The member shall be informed of the individual budget amount during the development of the service plan.

(1) Services that may be included in determining the individual budget amount for a member in the HCBS intellectual disabilities waiver are:

1. Consumer-directed attendant care (unskilled).
2. Day habilitation.
3. Home and vehicle modification.
4. Prevocational services.
5. Basic individual respite care.
6. Supported community living.
7. Supported employment.
8. Transportation.

(2) The department shall determine an average unit cost for each service listed in subparagraph 78.41(15) "b"(1) based on actual unit costs from the previous fiscal year plus a cost-of-living adjustment.

(3) In aggregate, costs for individual budget services shall not exceed the current costs of waiver program services. In order to maintain cost neutrality, the department shall apply a utilization adjustment factor to the amount of service authorized in the member's service plan before calculating the value of that service to be included in the individual budget amount.

(4) The department shall compute the utilization adjustment factor for each service by dividing the net costs of all claims paid for the service by the total of the authorized costs for that service, using at least 12 consecutive months of aggregate service data. The utilization adjustment factor shall be no lower than 60 percent. The department shall analyze and adjust the utilization adjustment factor at least annually in order to maintain cost neutrality.

(5) Individual budgets for respite services shall be computed based on the average cost for services identified in subparagraph 78.41(15) "b"(2). Respite services are not subject to the utilization adjustment factor in subparagraph 78.41(15) "b"(3).

(6) Anticipated costs for home and vehicle modification and supported employment services to obtain a job are not subject to the average cost in subparagraph 78.41(15)“b”(2) or the utilization adjustment factor in subparagraph 78.41(15)“b”(3). Anticipated costs for these services shall not include the costs of the financial management services or the independent support broker. Costs for home and vehicle modification and supported employment services to obtain a job may be paid to the financial management services provider in a one-time payment. Before becoming part of the individual budget, all home and vehicle modifications and supported employment services to obtain a job shall be identified in the member’s service plan and approved by the case manager or service worker.

(7) The individual budget amount may be changed only at the first of the month and shall remain fixed for the entire month.

c. Required service components. To participate in the consumer choices option, a member must hire an independent support broker and must work with a financial management service that is enrolled as a Medicaid provider. Before hiring the independent support broker, the member shall receive the results of the background check conducted pursuant to 441—Chapter 119.

d. Optional service components. A member who elects the consumer choices option may purchase the following goods, services and supports, which shall be provided in the member’s home or at an integrated community setting:

(1) Self-directed personal care services. Self-directed personal care services are services or goods that provide a range of assistance in activities of daily living and incidental activities of daily living that help the member remain in the home and community. These services must be identified in the member’s service plan developed by the member’s case manager or service worker.

(2) Self-directed community supports and employment. Self-directed community supports and employment are services that support the member in developing and maintaining independence and community integration. These services must be identified in the member’s service plan developed by the member’s case manager or service worker.

(3) Individual-directed goods and services. Individual-directed goods and services are services, equipment, or supplies not otherwise provided through the Medicaid program that address an assessed need or goal identified in the member’s service plan. The item or service shall meet the following requirements:

1. Promote opportunities for community living and inclusion.
2. Increase independence or substitute for human assistance, to the extent the expenditures would otherwise be made for that human assistance.
3. Be accommodated within the member’s budget without compromising the member’s health and safety.
4. Be provided to the member or directed exclusively toward the benefit of the member.
5. Be the least costly to meet the member’s needs.
6. Not be available through another source.

e. Development of the individual budget. The independent support broker shall assist the member in developing and implementing the member’s individual budget. The individual budget shall include:

- (1) The costs of the financial management service.
- (2) The costs of the independent support broker. The independent support broker may be compensated for up to 6 hours of service for assisting with the implementation of the initial individual budget. The independent support broker shall not be paid for more than 30 hours of service for an individual member during a 12-month period without prior approval by the department.

(3) The costs of any optional service component chosen by the member as described in paragraph 78.41(15)“d.” Costs of the following items and services shall not be covered by the individual budget:

1. Child care services.
2. Clothing not related to an assessed medical need.
3. Conference, meeting or similar venue expenses other than the costs of approved services the member needs while attending the conference, meeting or similar venue.
4. Costs associated with shipping items to the member.
5. Experimental and non-FDA-approved medications, therapies, or treatments.

6. Goods or services covered by other Medicaid programs.
7. Home furnishings.
8. Home repairs or home maintenance.
9. Homeopathic treatments.
10. Insurance premiums or copayments.
11. Items purchased on installment payments.
12. Motorized vehicles.
13. Nutritional supplements.
14. Personal entertainment items.
15. Repairs and maintenance of motor vehicles.
16. Room and board, including rent or mortgage payments.
17. School tuition.
18. Service animals.
19. Services covered by third parties or services that are the responsibility of a non-Medicaid program.

20. Sheltered workshop services.
21. Social or recreational purchases not related to an assessed need or goal identified in the member's service plan.
22. Vacation expenses, other than the costs of approved services the member needs while on vacation.

(4) The costs of any approved home or vehicle modification. When authorized, the budget may include an amount allocated for a home or vehicle modification. Before becoming part of the individual budget, all home and vehicle modifications shall be identified in the member's service plan and approved by the case manager or service worker. The authorized amount shall not be used for anything other than the specific modification.

(5) Any amount set aside in a savings plan to reserve funds for the future purchase of self-directed personal care, individual-directed goods and services, or self-directed community supports and services as defined in paragraph 78.41(15)“d.” The savings plan shall meet the requirements in paragraph 78.41(15)“f.”

f. Savings plan. A member savings plan must be in writing and be approved by the department before the start of the savings plan. Amounts allocated to the savings plan must result from efficiencies in meeting identified needs of the member.

- (1) The savings plan shall identify:
 1. The specific goods, services, supports or supplies to be purchased through the savings plan.
 2. The amount of the individual budget allocated each month to the savings plan.
 3. The amount of the individual budget allocated each month to meet the member's identified service needs.

4. How the member's assessed needs will continue to be met through the individual budget when funds are placed in savings.

(2) With the exception of funds allocated for respite care, the savings plan shall not include funds budgeted for direct services that were not received. The budgeted amount associated with unused direct services other than respite care shall revert to the Medicaid program at the end of each month. Funds from unused respite services may be allocated to the savings plan but shall not be used for anything other than future respite care.

(3) Funds accumulated under a savings plan shall be used only to purchase items that increase independence or substitute for human assistance to the extent that expenditures would otherwise be made for human assistance, including additional goods, supports, services or supplies. The self-directed personal care, individual-directed goods and services, or self-directed community supports and services purchased with funds from a savings plan must:

1. Be used to meet a member's identified need,
2. Be medically necessary, and
3. Be approved by the member's case manager or service worker.

(4) All funds allocated to a savings plan that are not expended by December 31 of each year shall revert to the Medicaid program.

(5) The annual reassessment of a member's needs must take into account the purchases of goods and services that substitute for human assistance. Adjustments shall be made to the services used to determine the individual budget based on the reassessment.

g. Budget authority. The member shall have authority over the individual budget authorized by the department to perform the following tasks:

(1) Contract with entities to provide services and supports as described in this subrule.

(2) Determine the amount to be paid for services. Reimbursement rates shall be consistent with rates paid by others in the community for the same or substantially similar services. Reimbursement rates for the independent support broker and the financial management service are subject to the limits in 441—subrule 79.1(2). The reimbursement rate for a member's legal representative who provides services to the member as allowed by 441—paragraph 79.9(7) “b” must be based on the skill level of the legal representative and may not exceed the median statewide reimbursement rate for the service unless the higher rate receives prior approval from the department.

(3) Schedule the provision of services. Whenever a member's legal representative provides services to the member as allowed by 441—paragraph 79.9(7) “b,” the legal representative may not be paid for more than 40 hours of service per week and a contingency plan must be established in the member's service plan to ensure service delivery in the event the legal representative is unable to provide services due to illness or other unexpected event.

(4) Authorize payment for optional service components identified in the individual budget.

(5) Reallocate funds among services included in the budget. Every purchase of a good or service must be identified and approved in the individual budget before the purchase is made.

h. Delegation of budget authority. The member may delegate responsibility for the individual budget to a representative in addition to the independent support broker.

(1) The representative must be at least 18 years old.

(2) The representative shall not be a current provider of service to the member.

(3) The member shall sign a consent form that designates who the member has chosen as a representative and what responsibilities the representative shall have.

(4) The representative shall not be paid for this service.

i. Employer authority. The member shall have the authority to be the common-law employer of employees providing services and support under the consumer choices option. A common-law employer has the right to direct and control the performance of the services. The member may perform the following functions:

(1) Recruit employees.

(2) Select employees from a worker registry.

(3) Verify employee qualifications.

(4) Specify additional employee qualifications.

(5) Determine employee duties.

(6) Determine employee wages and benefits.

(7) Schedule employees.

(8) Train and supervise employees.

j. Employment agreement. Any person employed by the member to provide services under the consumer choices option shall sign an employment agreement with the member that outlines the employee's and member's responsibilities.

k. Responsibilities of the independent support broker. The independent support broker shall perform the following services as directed by the member or the member's representative:

(1) Assist the member with developing the member's initial and subsequent individual budgets and with making any changes to the individual budget.

(2) Have monthly contact with the member for the first four months of implementation of the initial individual budget and have quarterly contact thereafter.

(3) Complete the required employment packet with the financial management service.

(4) Assist with interviewing potential employees and entities providing services and supports if requested by the member.

(5) Assist the member with determining whether a potential employee meets the qualifications necessary to perform the job.

(6) Assist the member with obtaining a signed consent from a potential employee to conduct background checks if requested by the member.

(7) Assist the member with negotiating with entities providing services and supports if requested by the member.

(8) Assist the member with contracts and payment methods for services and supports if requested by the member.

(9) Assist the member with developing an emergency backup plan. The emergency backup plan shall address any health and safety concerns.

(10) Review expenditure reports from the financial management service to ensure that services and supports in the individual budget are being provided.

(11) Document in writing on the independent support broker timecard every contact the broker has with the member. Contact documentation shall include information on the extent to which the member's individual budget has addressed the member's needs and the satisfaction of the member.

l. Responsibilities of the financial management service. The financial management service shall perform all of the following services:

(1) Receive Medicaid funds in an electronic transfer.

(2) Process and pay invoices for approved goods and services included in the individual budget.

(3) Enter the individual budget into the Web-based tracking system chosen by the department and enter expenditures as they are paid.

(4) Provide real-time individual budget account balances for the member, the independent support broker, and the department, available at a minimum during normal business hours (9 a.m. to 5 p.m., Monday through Friday).

(5) Conduct criminal background checks on potential employees pursuant to 441—Chapter 119.

(6) Verify for the member an employee's citizenship or alien status.

(7) Assist the member with fiscal and payroll-related responsibilities including, but not limited to:

1. Verifying that hourly wages comply with federal and state labor rules.

2. Collecting and processing timecards.

3. Withholding, filing, and paying federal, state and local income taxes, Medicare and Social Security (FICA) taxes, and federal (FUTA) and state (SUTA) unemployment and disability insurance taxes, as applicable.

4. Computing and processing other withholdings, as applicable.

5. Processing all judgments, garnishments, tax levies, or other withholding on an employee's pay as may be required by federal, state, or local laws.

6. Preparing and issuing employee payroll checks.

7. Preparing and disbursing IRS Forms W-2 and W-3 annually.

8. Processing federal advance earned income tax credit for eligible employees.

9. Refunding over-collected FICA, when appropriate.

10. Refunding over-collected FUTA, when appropriate.

(8) Assist the member in completing required federal, state, and local tax and insurance forms.

(9) Establish and manage documents and files for the member and the member's employees.

(10) Monitor timecards, receipts, and invoices to ensure that they are consistent with the individual budget. Keep records of all timecards and invoices for each member for a total of five years.

(11) Provide to the department, the independent support broker, and the member monthly and quarterly status reports that include a summary of expenditures paid and amount of budget unused.

(12) Establish an accessible customer service system and a method of communication for the member and the independent support broker that includes alternative communication formats.

(13) Establish a customer services complaint reporting system.

(14) Develop a policy and procedures manual that is current with state and federal regulations and update as necessary.

(15) Develop a business continuity plan in the case of emergencies and natural disasters.

(16) Provide to the department an annual independent audit of the financial management service.

(17) Assist in implementing the state's quality management strategy related to the financial management service.

78.41(16) General service standards. All intellectual disability waiver services must be provided in accordance with the following standards:

a. Reimbursement shall not be available under the waiver for any services that the member can obtain as other nonwaiver Medicaid services or through any other funding source.

b. All services provided under the waiver must be delivered in the least restrictive environment possible and in conformity with the member's service plan.

c. Services must be billed in whole units.

d. For all services with a 15-minute unit of service, the following rounding process will apply:

(1) Add together the minutes spent on all billable activities during a calendar day for a daily total.

(2) For each day, divide the total minutes spent on billable activities by 15 to determine the number of full 15-minute units for that day.

(3) Round the remainder using these guidelines: Round 1 to 7 minutes down to zero units; round 8 to 14 minutes up to one unit.

(4) Add together the number of full units and the number of rounded units to determine the total number of units to bill for that day.

This rule is intended to implement Iowa Code section 249A.4.

[ARC 9045B, IAB 9/8/10, effective 11/1/10; ARC 9403B, IAB 3/9/11, effective 5/1/11 (See Delay note at end of chapter); ARC 9650B, IAB 8/10/11, effective 10/1/11; ARC 9704B, IAB 9/7/11, effective 9/1/11; ARC 9884B, IAB 11/30/11, effective 1/4/12; ARC 0707C, IAB 5/1/13, effective 7/1/13; ARC 0709C, IAB 5/1/13, effective 7/1/13; ARC 0842C, IAB 7/24/13, effective 7/1/13; ARC 1056C, IAB 10/2/13, effective 11/6/13; ARC 1071C, IAB 10/2/13, effective 10/1/13; ARC 1610C, IAB 9/3/14, effective 8/13/14]

441—78.42(249A) Pharmacies administering influenza vaccine to children. Payment will be made to a pharmacy for the administration of influenza vaccine available through the Vaccines for Children (VFC) Program administered by the department of public health if the pharmacy is enrolled in the VFC program. Payment will be made for the vaccine only if the VFC program stock has been depleted.

This rule is intended to implement Iowa Code section 249A.4.

[ARC 9132B, IAB 10/6/10, effective 11/1/10; ARC 9316B, IAB 12/29/10, effective 2/2/11; ARC 0065C, IAB 4/4/12, effective 6/1/12]

441—78.43(249A) HCBS brain injury waiver services. Payment shall be approved for the following services to members eligible for the HCBS brain injury waiver services as established in 441—Chapter 83 and as identified in the member's service plan.

78.43(1) Case management services. Individual case management services means services that assist members who reside in a community setting or are transitioning to a community setting in gaining access to needed medical, social, educational, housing, transportation, vocational, and other appropriate services in order to ensure the health, safety, and welfare of the member.

a. Case management services shall be provided as set forth in rules 441—90.5(249A) and 441—90.8(249A).

b. The service shall be delivered in such a way as to enhance the capabilities of consumers and their families to exercise their rights and responsibilities as citizens in the community. The goal is to enhance the ability of the consumer to exercise choice, make decisions, take risks that are a typical part of life, and fully participate as members of the community.

c. The case manager must develop a relationship with the consumer so that the abilities, needs and desires of the consumer can be clearly identified and communicated and the case manager can help to ensure that the system and specific services are responsive to the needs of the individual consumers.

d. Members who are eligible for targeted case management are not eligible for case management as a waiver service.

78.43(2) *Supported community living services.* Supported community living services are provided by the provider within the member's home and community, according to the individualized member need as identified in the service plan.

a. The basic components of the service may include, but are not limited to, personal and home skills training services, individual advocacy services, community skills training services, personal environment support services, transportation, and treatment services.

(1) Personal and home skills training services are activities which assist a member to develop or maintain skills for self-care, self-directedness, and care of the immediate environment.

(2) Individual advocacy is the act or process of representing the member's rights and interests in order to realize the rights to which the member is entitled and to remove barriers to meeting the member's needs.

(3) Community skills training services are activities which assist a member to develop or maintain skills allowing better participation in the community. Services shall focus on the following areas as they apply to the member being served:

1. Personal management skills training services are activities which assist a member to maintain or develop skills necessary to sustain the member in the physical environment and are essential to the management of the member's personal business and property. This includes self-advocacy skills. Examples of personal management skills are the ability to maintain a household budget, plan and prepare nutritional meals, use community resources such as public transportation and libraries, and select foods at the grocery store.

2. Socialization skills training services are activities which assist a member to develop or maintain skills which include self-awareness and self-control, social responsiveness, community participation, social amenities, and interpersonal skills.

3. Communication skills training services are activities which assist a member to develop or maintain skills including expressive and receptive skills in verbal and nonverbal language and the functional application of acquired reading and writing skills.

(4) Personal and environmental support services are those activities and expenditures provided to or on behalf of a member in the areas of personal needs in order to allow the member to function in the least restrictive environment.

(5) Transportation services are activities and expenditures designed to assist the member to travel from one place to another to obtain services or carry out life's activities. The service excludes transportation to and from work or day programs.

(6) Treatment services are activities designed to assist the member to maintain or improve physiological, emotional and behavioral functioning and to prevent conditions that would present barriers to the member's functioning. Treatment services include physical or physiological treatment and psychotherapeutic treatment.

1. Physiological treatment includes medication regimens designed to prevent, halt, control, relieve, or reverse symptoms or conditions which interfere with the normal functioning of the human body. Physiological treatment shall be provided by or under the direct supervision of a certified or licensed health care professional.

2. Psychotherapeutic treatment means activities provided to assist a member in the identification or modification of beliefs, emotions, attitudes, or behaviors in order to maintain or improve the member's functioning in response to the physical, emotional, and social environment.

b. The supported community living services are intended to provide for the daily living needs of the member and shall be available as needed during any 24-hour period. Activities do not include those associated with vocational services, academics, day care, medical services, Medicaid case management or other case management. Services are individualized supportive services provided in a variety of community-based, integrated settings.

(1) Supported community living services shall be available at a daily rate to members living outside the home of their family, legal representative, or foster family and for whom a provider has primary responsibility for supervision or structure during the month. This service shall provide supervision or structure in identified periods when another resource is not available.

(2) Supported community living services shall be available at a 15-minute rate to members for whom a daily rate is not established.

c. Services may be provided to a child or an adult. Children must first access all other services for which they are eligible and which are appropriate to meet their needs before accessing the HCBS brain injury waiver services. A maximum of four persons may reside in a living unit.

(1) A member may live in the home of the member's family or legal representative or in another typical community living arrangement.

(2) A member living with the member's family or legal representative is not subject to the maximum of four residents in a living unit.

(3) A member may not live in a licensed medical or health care facility or in a setting that is required to be licensed as a medical or health care facility.

d. A member aged 17 or under living in the home of the member's family, legal representative, or foster family shall receive services based on development of adaptive, behavior, or health skills. Duration of services shall be based on age-appropriateness and individual attention span.

e. Provider budgets shall reflect all staff-to-member ratios and shall reflect costs associated with members' specific support needs for travel and transportation, consulting, instruction, and environmental modifications and repairs, as determined necessary by the interdisciplinary team for each member. The specific support needs must be identified in the Medicaid case manager's service plan, the total costs shall not exceed \$1570 per member per year, and the provider must maintain records to support the expenditures. A unit of service is:

(1) One full calendar day when a member residing in the living unit receives on-site staff supervision for eight or more hours per day as an average over a calendar month and the member's service plan identifies and reflects the need for this amount of supervision.

(2) Fifteen minutes when subparagraph 78.43(2)"e"(1) does not apply.

f. The maximum number of units available per member is as follows:

(1) 365 daily units per state fiscal year except a leap year, when 366 daily units are available.

(2) 33,580 15-minute units per state fiscal year except a leap year, when 33,672 15-minute units are available.

g. The service shall be identified in the member's service plan.

h. Supported community living services shall not be simultaneously reimbursed with other residential services or with respite, transportation, personal assistance, nursing, or home health aide services provided through Medicaid or the HCBS brain injury waiver.

78.43(3) Respite care services. Respite care services are services provided to the member that give temporary relief to the usual caregiver and provide all the necessary care that the usual caregiver would provide during that period. The purpose of respite care is to enable the member to remain in the member's current living situation.

a. Services provided outside the member's home shall not be reimbursable if the living unit where respite is provided is reserved for another person on a temporary leave of absence.

b. Member-to-staff ratios shall be appropriate to the individual needs of the member as determined by the member's interdisciplinary team.

c. A unit of service is 15 minutes.

d. Respite care is not to be provided to members during the hours in which the usual caregiver is employed except when the member is attending a 24-hour residential camp. Respite care shall not be used as a substitute for a child's day care. Respite care cannot be provided to a member whose usual caregiver is a consumer-directed attendant care provider for the member.

e. The interdisciplinary team shall determine if the member will receive basic individual respite, specialized respite or group respite as defined in 441—Chapter 83.

f. A maximum of 14 consecutive days of 24-hour respite care may be reimbursed.

g. Respite services provided for a period exceeding 24 consecutive hours to three or more individuals who require nursing care because of a mental or physical condition must be provided by a health care facility licensed as described in Iowa Code chapter 135C.

h. Respite services shall not be provided simultaneously with other residential, supported community living services, nursing, or home health aide services provided through the medical assistance program.

78.43(4) Supported employment services. Supported employment services are individualized services associated with obtaining and maintaining competitive paid employment in the least restrictive environment possible, provided to individuals for whom competitive employment at or above minimum wage is unlikely and who, because of their disability, need intense and ongoing support to perform in a work setting. Individual placements are the preferred service model. Covered services are those listed in paragraphs “a” and “b” that address the disability-related challenges to securing and keeping a job.

a. Activities to obtain a job. Covered services directed to obtaining a job must be provided to or on behalf of a member for whom competitive employment is reasonably expected within less than one year. Services must be focused on job placement, not on teaching generalized employment skills or habilitative goals. Three conditions must be met before services are provided. First, the member and the interdisciplinary team described in rule 441—83.87(249A) must complete the form that Iowa vocational rehabilitation services uses to identify the supported employment services appropriate to meet the member’s employment needs. Second, the member’s interdisciplinary team must determine that the identified services are necessary. Third, the member’s case manager must approve the services. Available components of activities to obtain a job are as follows:

(1) Job development services. Job development services are directed toward obtaining competitive employment. A unit of service is a job placement that the member holds for 30 consecutive calendar days or more. Payment is available once the service is authorized in the member’s service plan. A member may receive two units of job development services during a 12-month period. The activities provided to the member may include:

1. Job procurement training, including grooming and hygiene, application, résumé development, interviewing skills, follow-up letters, and job search activities.
2. Job retention training, including promptness, coworker relations, transportation skills, disability-related supports, job benefits, and an understanding of employee rights and self-advocacy.
3. Customized job development services specific to the member.

(2) Employer development services. The focus of employer development services is to support employers in hiring and retaining members in their workforce and to communicate expectations of the employers to the interdisciplinary team described in rule 441—83.87(249A). Employer development services may be provided only to members who are reasonably expected to work for no more than 10 hours per week. A unit of service is one job placement that the member holds for 30 consecutive calendar days or more. Payment for this service may be made only after the member holds the job for 30 days. A member may receive two units of employer development services during a 12-month period if the member is competitively employed for 30 or more consecutive calendar days and the other conditions for service approval are met. The services provided may include:

1. Developing relationships with employers and providing leads for individual members when appropriate.
2. Job analysis for a specific job.
3. Development of a customized training plan identifying job-specific skill requirements, employer expectations, teaching strategies, time frames, and responsibilities.
4. Identifying and arranging reasonable accommodations with the employer.
5. Providing disability awareness and training to the employer when it is deemed necessary.
6. Providing technical assistance to the employer regarding the training progress as identified on the member’s customized training plan.

(3) Enhanced job search activities. Enhanced job search activities are associated with obtaining initial employment after job development services have been provided to the member for a minimum of 30 days or with assisting the member in changing jobs due to layoff, termination, or personal choice. The interdisciplinary team must review and update the Iowa vocational rehabilitation services supported employment readiness analysis form to determine if this service remains appropriate for the member’s

employment goals. A unit of service is 15 minutes. A maximum of 104 units may be provided in a 12-month period. The services provided may include:

1. Job opening identification with the member.
2. Assistance with applying for a job, including completion of applications or interviews.
3. Work site assessment and job accommodation evaluation.
- b. Supports to maintain employment.

(1) Covered services provided to or on behalf of the member associated with maintaining competitive paid employment are the following:

1. Individual work-related behavioral management.
2. Job coaching.
3. On-the-job or work-related crisis intervention.
4. Assisting the member to use skills related to sustaining competitive paid employment, including assistance with communication skills, problem solving, and safety.
5. Consumer-directed attendant care services as defined in subrule 78.43(13).
6. Assistance with time management.
7. Assistance with appropriate grooming.
8. Employment-related supportive contacts.
9. Employment-related transportation between work and home and to or from activities related to employment and disability. Other forms of community transportation (including car pools, coworkers, self or public transportation, families, and volunteers) must be attempted before transportation is provided as a supported employment service.

10. On-site vocational assessment after employment.
11. Employer consultation.

(2) Services for maintaining employment may include services associated with sustaining members in a team of no more than eight individuals with disabilities in a teamwork or “enclave” setting.

- (3) A unit of service is 15 minutes.
- (4) A maximum of 160 units may be received per week.

c. The following requirements apply to all supported employment services:

(1) Employment-related adaptations required to assist the member within the performance of the member’s job functions shall be provided by the provider as part of the services.

(2) Employment-related transportation between work and home and to or from activities related to employment and disability shall be provided by the provider as part of the services. Other forms of community transportation (car pools, coworkers, self or public transportation, families, volunteers) must be attempted before the service provider provides transportation.

(3) The majority of coworkers at any employment site with more than two employees where members seek, obtain, or maintain employment must be persons without disabilities. In the performance of job duties at any site where members seek, obtain, or maintain employment, the member must have daily contact with other employees or members of the general public who do not have disabilities, unless the absence of daily contact with other employees or the general public is typical for the job as performed by persons without disabilities.

(4) All supported employment services shall provide individualized and ongoing support contacts at intervals necessary to promote successful job retention. Each provider contact shall be documented.

(5) Documentation that services provided are not currently available under a program funded under the Rehabilitation Act of 1973 or Public Law 94-142 shall be maintained in the provider file of each member.

(6) All services shall be identified in the member’s service plan maintained pursuant to rule 441—83.67(249A).

(7) The following services are not covered:

1. Services involved in placing or maintaining members in day activity programs, work activity programs or sheltered workshop programs;
2. Supports for volunteer work or unpaid internships;
3. Tuition for education or vocational training; or

4. Individual advocacy that is not member specific.

(8) Services to maintain employment shall not be provided simultaneously with day activity programs, work activity programs, sheltered workshop programs, other HCBS services, or other Medicaid services. However, services to obtain a job and services to maintain employment may be provided simultaneously for the purpose of job advancement or job change.

78.43(5) Home and vehicle modification. Covered home or vehicle modifications are physical modifications to the member's home or vehicle that directly address the member's medical or remedial need. Covered modifications must be necessary to provide for the health, welfare, or safety of the member and enable the member to function with greater independence in the home or vehicle.

a. Modifications that are necessary or desirable without regard to the member's medical or remedial need and that would be expected to increase the fair market value of the home or vehicle, such as furnaces, fencing, or adding square footage to the residence, are excluded except as specifically included below. Purchasing or leasing of a motorized vehicle is excluded. Home and vehicle repairs are also excluded.

b. Only the following modifications are covered:

(1) Kitchen counters, sink space, cabinets, special adaptations to refrigerators, stoves, and ovens.
(2) Bathtubs and toilets to accommodate transfer, special handles and hoses for shower heads, water faucet controls, and accessible showers and sink areas.

(3) Grab bars and handrails.

(4) Turnaround space adaptations.

(5) Ramps, lifts, and door, hall and window widening.

(6) Fire safety alarm equipment specific for disability.

(7) Voice-activated, sound-activated, light-activated, motion-activated, and electronic devices directly related to the member's disability.

(8) Vehicle lifts, driver-specific adaptations, remote-start systems, including such modifications already installed in a vehicle.

(9) Keyless entry systems.

(10) Automatic opening device for home or vehicle door.

(11) Special door and window locks.

(12) Specialized doorknobs and handles.

(13) Plexiglas replacement for glass windows.

(14) Modification of existing stairs to widen, lower, raise or enclose open stairs.

(15) Motion detectors.

(16) Low-pile carpeting or slip-resistant flooring.

(17) Telecommunications device for the deaf.

(18) Exterior hard-surface pathways.

(19) New door opening.

(20) Pocket doors.

(21) Installation or relocation of controls, outlets, switches.

(22) Air conditioning and air filtering if medically necessary.

(23) Heightening of existing garage door opening to accommodate modified van.

(24) Bath chairs.

c. A unit of service is the completion of needed modifications or adaptations.

d. All modifications and adaptations shall be provided in accordance with applicable federal, state, and local building and vehicle codes.

e. Services shall be performed following prior department approval of the modification as specified in 441—subrule 79.1(17) and a binding contract between the provider and the member.

f. All contracts for home or vehicle modification shall be awarded through competitive bidding. The contract shall include the scope of work to be performed, the time involved, supplies needed, the cost, diagrams of the project whenever applicable, and an assurance that the provider has liability and workers' compensation coverage and the applicable permit and license.

g. Service payment shall be made to the enrolled home or vehicle modification provider. If applicable, payment will be forwarded to the subcontracting agency by the enrolled home or vehicle modification provider following completion of the approved modifications. Payment of up to \$6,366.64 per year may be made to certified providers upon satisfactory completion of the service. The case manager or service worker may encumber a portion of the cost of a modification every month within the monthly dollar cap allowed for the member until the entire cost of the modification is encumbered within a consecutive 12-month period.

h. Services shall be included in the member's service plan and shall exceed the Medicaid state plan services.

78.43(6) *Personal emergency response or portable locator system.*

a. A personal emergency response system is an electronic device that transmits a signal to a central monitoring station to summon assistance in the event of an emergency.

(1) The necessary components of a system are:

1. An in-home medical communications transceiver.
2. A remote, portable activator.
3. A central monitoring station with backup systems staffed by trained attendants at all times.
4. Current data files at the central monitoring station containing response protocols and personal, medical and emergency information for each member.

(2) The service shall be identified in the member's service plan.

(3) A unit is a one-time installation fee or one month of service.

(4) Maximum units per state fiscal year shall be the initial installation and 12 months of service.

b. A portable locator system is an electronic device that transmits a signal to a monitoring device. The system allows a member to access assistance in the event of an emergency and allows law enforcement or the monitoring system provider to locate a member who is unable to request help or to activate a system independently. The member must be unable to access assistance in an emergency situation due to the member's age or disability.

(1) The required components of the portable locator system are:

1. A portable communications transceiver or transmitter to be worn or carried by the member.
2. Monitoring by the provider at a central location with response protocols and personal, medical, and emergency information for each member as applicable.

(2) The service shall be identified in the member's service plan.

(3) Payable units of service are purchase of equipment, an installation or set-up fee, and monthly fees.

(4) Maximum units per state fiscal year shall be one equipment purchase, one installation or set-up fee, and 12 months of service.

78.43(7) *Transportation.* Transportation services may be provided for members to conduct business errands and essential shopping, to receive medical services when not reimbursed through nonemergency medical transportation, to travel to and from work or day programs, and to reduce social isolation. A unit of service is one mile of transportation or one one-way trip. Transportation may not be reimbursed simultaneously with HCBS brain injury waiver supported community living service when the transportation costs are included within the supported community living reimbursement rate.

78.43(8) *Specialized medical equipment.*

a. Specialized medical equipment shall include medically necessary items which are for personal use by members with a brain injury and which:

- (1) Provide for health and safety of the member,
- (2) Are not ordinarily covered by Medicaid,
- (3) Are not funded by educational or vocational rehabilitation programs, and
- (4) Are not provided by voluntary means.

b. Coverage includes, but is not limited to:

- (1) Electronic aids and organizers.
- (2) Medicine dispensing devices.
- (3) Communication devices.

- (4) Bath aids.
- (5) Noncovered environmental control units.
- (6) Repair and maintenance of items purchased through the waiver.

c. Payment of up to \$6,060 per year may be made to enrolled specialized medical equipment providers upon satisfactory receipt of the service. Each month within the 12-month period, the service worker shall encumber an amount within the monthly dollar cap allowed for the member until the amount of the equipment cost is reached.

d. The need for specialized medical equipment shall be:

- (1) Documented by a health care professional as necessary for the member's health and safety, and
- (2) Identified in the member's service plan.

e. Payment for most items shall be based on a fee schedule. The amount of the fee shall be determined as directed in 441—subrule 79.1(17).

78.43(9) *Adult day care services.* Adult day care services provide an organized program of supportive care in a group environment to persons who need a degree of supervision and assistance on a regular or intermittent basis in a day care center. A unit of service is 15 minutes (up to four units per day), a half day (1.25 to 4 hours per day), a full day (4.25 to 8 hours per day), or an extended day (8.25 to 12 hours per day). Components of the service include health-related care, social services, and other related support services.

78.43(10) *Family counseling and training services.* Family counseling and training services are face-to-face mental health services provided to the consumer and the family with whom the consumer lives, or who routinely provide care to the consumer to increase the consumer's or family members' capabilities to maintain and care for the consumer in the community. Counseling may include helping the consumer or the consumer's family members with crisis, coping strategies, stress reduction, management of depression, alleviation of psychosocial isolation and support in coping with the effects of a brain injury. It may include the use of treatment regimes as specified in the ITP. Periodic training updates may be necessary to safely maintain the consumer in the community.

Family may include spouse, children, friends, or in-laws of the consumer. Family does not include individuals who are employed to care for the consumer.

78.43(11) *Prevocational services.* Prevocational services are services which are aimed at preparing a member for paid or unpaid employment, but which are not job-task oriented. These services include teaching the member concepts necessary for job readiness, such as following directions, attending to tasks, task completion, problem solving, and safety and mobility training.

a. Prevocational services are intended to have a more generalized result as opposed to vocational training for a specific job or supported employment. Services include activities which are not primarily directed at teaching specific job skills but at more generalized habilitative goals and are reflected in a habilitative plan which focuses on general habilitative rather than specific employment objectives.

b. Prevocational services do not include:

(1) Services defined in Section 4(a)(4) of the 1975 amendments to the Education of the Handicapped Act (20 U.S.C. 1404(16) and (17)) which are otherwise available to the member through a state or local education agency, or

(2) Vocational rehabilitation services which are otherwise available to the member through a program funded under Section 110 of the Rehabilitation Act of 1973 (29 U.S.C. 730).

c. A unit of service is a full day (4.25 to 8 hours per day) or an hour (for up to 4 hours per day).

78.43(12) *Behavioral programming.* Behavioral programming consists of individually designed strategies to increase the consumer's appropriate behaviors and decrease the consumer's maladaptive behaviors which have interfered with the consumer's ability to remain in the community. Behavioral programming includes:

- a. A complete assessment of both appropriate and maladaptive behaviors.
- b. Development of a structured behavioral intervention plan which should be identified in the ITP.
- c. Implementation of the behavioral intervention plan.
- d. Ongoing training and supervision to caregivers and behavioral aides.
- e. Periodic reassessment of the plan.

Types of appropriate behavioral programming include, but are not limited to, clinical redirection, token economies, reinforcement, extinction, modeling, and over-learning.

78.43(13) Consumer-directed attendant care service. Consumer-directed attendant care services are service activities performed by a person to help a member with self-care tasks which the member would typically do independently if the member were otherwise able. Covered service activities are limited to the nonskilled activities listed in paragraph 78.43(13) “f” and the skilled activities listed in paragraph 78.43(13) “g.” Covered service activities must be essential to the health, safety, and welfare of the member. Services may be provided in the absence of a parent or guardian if the parent or guardian has given advance direction for the service provision.

a. Service planning.

(1) The member, parent, guardian, or attorney in fact under a durable power of attorney for health care shall:

1. Select the individual or agency that will provide the components of the attendant care services.
2. Determine with the selected provider what components of attendant care services the provider shall perform, subject to confirmation by the service worker or case manager that those components are consistent with the assessment and are authorized covered services.

3. Complete, sign, and date Form 470-3372, HCBS Consumer-Directed Attendant Care Agreement, to indicate the frequency, scope, and duration of services (a description of each service component and the time agreed on for that component). The case manager or service worker and provider shall also sign the agreement.

4. Submit the completed agreement to the service worker or case manager. The agreement shall be part of the member’s service plan and shall be kept in the member’s records, in the provider’s records, and in the service worker’s or case manager’s records. Any service component that is not listed in the agreement shall not be payable.

(2) Whenever a legal representative acts as a provider of consumer-directed attendant care as allowed by 441—paragraph 79.9(7) “b,” the following shall apply:

1. The payment rate for the legal representative must be based on the skill level of the legal representative and may not exceed the median statewide reimbursement rate for the service unless the higher rate receives prior approval from the department;

2. The legal representative may not be paid for more than 40 hours of service per week; and

3. A contingency plan must be established in the member’s service plan to ensure service delivery in the event the legal representative is unable to provide services due to illness or other unexpected event.

b. Supervision of skilled services. Skilled consumer-directed attendant care services shall be provided under the supervision of a licensed nurse or licensed therapist working under the direction of a physician. The licensed nurse or therapist shall:

(1) Retain accountability for actions that are delegated.

(2) Ensure appropriate assessment, planning, implementation, and evaluation.

(3) Make on-site supervisory visits every two weeks with the service provider present.

c. Service documentation. The consumer-directed attendant care provider must complete Form 470-4389, Consumer-Directed Attendant Care (CDAC) Service Record, for each day of service. Any service component that is not documented in accordance with rule 441—79.3(249A) shall not be payable.

d. Role of guardian or attorney. If the member has a guardian or attorney in fact under a durable power of attorney for health care:

(1) The service worker’s or case manager’s service plan shall address how consumer-directed attendant care services will be monitored to ensure that the member’s needs are being adequately met. If the guardian or attorney in fact is the service provider, the service plan shall address how the service worker or case manager shall oversee service provision.

(2) The guardian or attorney in fact shall sign the claim form in place of the member, indicating that the service has been provided as presented on the claim.

e. Service units and billing. A unit of service is 15 minutes provided by an individual or agency. Each service shall be billed in whole units.

f. Nonskilled services. Covered nonskilled service activities are limited to help with the following activities:

- (1) Dressing.
- (2) Bathing, shampooing, hygiene, and grooming.
- (3) Access to and from bed or a wheelchair, transferring, ambulation, and mobility in general.
- (4) Toileting, including bowel, bladder, and catheter assistance (emptying the catheter bag, collecting a specimen, and cleaning the external area around the catheter).
- (5) Meal preparation, cooking, and assistance with feeding, not including the cost of meals themselves. Meal preparation and cooking shall be provided only in the member's home.
- (6) Housekeeping, laundry, and shopping essential to the member's health care at home.
- (7) Taking medications ordinarily self-administered, including those ordered by a physician or other qualified health care provider.
- (8) Minor wound care.
- (9) Going to or returning from a place of employment and job-related tasks while the member is on the job site. Transportation for the member and assistance with understanding or performing the essential job functions are not included in consumer-directed attendant care services.
- (10) Tasks, such as financial management and scheduling, that require cognitive or physical assistance.
- (11) Communication essential to the health and welfare of the member, through interpreting and reading services and use of assistive devices for communication.
- (12) Using transportation essential to the health and welfare of the member. The cost of the transportation is not included.

g. Skilled services. Covered skilled service activities are limited to help with the following activities:

- (1) Tube feedings of members unable to eat solid foods.
- (2) Intravenous therapy administered by a registered nurse.
- (3) Parenteral injections required more than once a week.
- (4) Catheterizations, continuing care of indwelling catheters with supervision of irrigations, and changing of Foley catheters when required.
- (5) Respiratory care including inhalation therapy and tracheotomy care or tracheotomy care and ventilator.
- (6) Care of decubiti and other ulcerated areas, noting and reporting to the nurse or therapist.
- (7) Rehabilitation services including, but not limited to, bowel and bladder training, range of motion exercises, ambulation training, restorative nursing services, respiratory care and breathing programs, reality orientation, reminiscing therapy, remotivation, behavior modification, and reteaching of the activities of daily living.
- (8) Colostomy care.
- (9) Care of uncontrolled medical conditions, such as brittle diabetes, and comfort care of terminal conditions.
- (10) Postsurgical nursing care.
- (11) Monitoring medications requiring close supervision because of fluctuating physical or psychological conditions, e.g., antihypertensives, digitalis preparations, mood-altering or psychotropic drugs, or narcotics.
- (12) Preparing and monitoring response to therapeutic diets.
- (13) Recording and reporting of changes in vital signs to the nurse or therapist.

h. Excluded services and costs. Services, activities, costs and time that are not covered as consumer-directed attendant care include the following (not an exclusive list):

- (1) Any activity related to supervising a member. Only direct services are billable.
- (2) Any activity that the member is able to perform.
- (3) Costs of food.
- (4) Costs for the supervision of skilled services by the nurse or therapist. The supervising nurse or therapist may be paid from private insurance, Medicare, or other third-party payment sources, or may

be paid as another Medicaid service, including early and periodic screening, diagnosis and treatment services.

- (5) Exercise that does not require skilled services.
- (6) Parenting or child care for or on behalf of the member.
- (7) Reminders and cueing.
- (8) Services provided simultaneously with any other similar service regardless of funding source, including other waiver services and state supplementary assistance in-home health-related care services.
- (9) Transportation costs.
- (10) Wait times for any activity.

78.43(14) *Interim medical monitoring and treatment services.* Interim medical monitoring and treatment (IMMT) services are monitoring and treatment of a medical nature for children or adults whose medical needs make alternative care unavailable, inadequate, or insufficient. IMMT services are not intended to provide day care but to supplement available resources. Services must be ordered by a physician.

a. Need for service. The member must be currently receiving home health agency services under rule 441—78.9(249A) and require medical assessment, medical monitoring, and regular medical intervention or intervention in a medical emergency during those services. The service worker or case manager must identify the need for IMMT services after evaluating the member's living environment, family and natural supports, ability to perform activities of daily living, and health care needs. The services must be needed:

- (1) To allow the member's usual caregivers to be employed,
- (2) During a search for employment by a usual caregiver,
- (3) To allow for academic or vocational training of a usual caregiver,
- (4) Due to the hospitalization of a usual caregiver for treatment for physical or mental illness, or
- (5) Due to the death of a usual caregiver.

b. Service requirements. Interim medical monitoring and treatment services shall:

- (1) Provide experiences for each member's social, emotional, intellectual, and physical development;
- (2) Include comprehensive developmental care and any special services for a member with special needs; and

- (3) Include medical assessment, medical monitoring, and medical intervention as needed on a regular or emergency basis. Medical intervention means the ability to assess the situation and contact the appropriate medical professional, not the direct application of medical care.

c. Interim medical monitoring and treatment services may include supervision while the member is being transported to and from school.

d. Limitations.

- (1) A maximum of 12 hours of service is available per day.
- (2) Covered services do not include a complete nutritional regimen.
- (3) Interim medical monitoring and treatment services may not duplicate any regular Medicaid or waiver services provided under the state plan. Services under the state plan, including home health agency services under rule 441—78.9(249A), must be exhausted before IMMT services are accessed.

- (4) Interim medical monitoring and treatment services shall be provided only in the member's home; in a registered child development home; in a licensed child care center, residential care facility, or adult day care facility; or during the time when the member is being transported to and from school.

- (5) The member-to-staff ratio shall not be more than six members to one staff person.

- (6) The parent or guardian of the member shall be responsible for the usual and customary nonmedical cost of day care during the time in which the member is receiving IMMT services. Medical care necessary for monitoring and treatment is an allowable IMMT cost. If the cost of care goes above the usual and customary cost of day care services due to the member's medical condition, the costs above the usual and customary cost shall be covered as IMMT services.

e. A unit of service is 15 minutes.

78.43(15) Consumer choices option. The consumer choices option provides a member with a flexible monthly individual budget that is based on the member's service needs. With the individual budget, the member shall have the authority to purchase goods and services to meet the member's assessed needs and may choose to employ providers of services and supports. The services, supports, and items that are purchased with an individual budget must be directly related to a member's assessed need or goal established in the member's service plan. Components of this service are set forth below.

a. Agreement. As a condition of participating in the consumer choices option, a member shall sign Form 470-4289, HCBS Consumer Choices Informed Consent and Risk Agreement, to document that the member has been informed of the responsibilities and risks of electing the consumer choices option.

b. Individual budget amount. A monthly individual budget amount shall be established for each member based on the assessed needs of the member and based on the services and supports authorized in the member's service plan. The member shall be informed of the individual budget amount during the development of the service plan.

(1) Services that may be included in determining the individual budget amount for a member in the HCBS brain injury waiver are:

1. Consumer-directed attendant care (unskilled).
2. Day habilitation.
3. Home and vehicle modification.
4. Prevocational services.
5. Basic individual respite care.
6. Specialized medical equipment.
7. Supported community living.
8. Supported employment.
9. Transportation.

(2) The department shall determine an average unit cost for each service listed in subparagraph 78.43(15) "b"(1) based on actual unit costs from the previous fiscal year plus a cost-of-living adjustment.

(3) In aggregate, costs for individual budget services shall not exceed the current costs of waiver program services. In order to maintain cost neutrality, the department shall apply a utilization adjustment factor to the amount of service authorized in the member's service plan before calculating the value of that service to be included in the individual budget amount.

(4) The department shall compute the utilization adjustment factor for each service by dividing the net costs of all claims paid for the service by the total of the authorized costs for that service, using at least 12 consecutive months of aggregate service data. The utilization adjustment factor shall be no lower than 60 percent. The department shall analyze and adjust the utilization adjustment factor at least annually in order to maintain cost neutrality.

(5) Individual budgets for respite services shall be computed based on the average cost for services identified in subparagraph 78.43(15) "b"(2). Respite services are not subject to the utilization adjustment factor in subparagraph 78.43(15) "b"(3).

(6) Anticipated costs for home and vehicle modification, specialized medical equipment, and supported employment services to obtain a job are not subject to the average cost in subparagraph 78.43(15) "b"(2) or the utilization adjustment factor in subparagraph 78.43(15) "b"(3). Anticipated costs for these services shall not include the costs of the financial management services or the independent support broker. Before becoming part of the individual budget, all home and vehicle modifications, specialized medical equipment, and supported employment services to obtain a job shall be identified in the member's service plan and approved by the case manager or service worker. Costs for these services may be paid to the financial management services provider in a one-time payment.

(7) The individual budget amount may be changed only at the first of the month and shall remain fixed for the entire month.

c. Required service components. To participate in the consumer choices option, a member must hire an independent support broker and must work with a financial management service that is enrolled as a Medicaid provider. Before hiring the independent support broker, the member shall receive the results of the background check conducted pursuant to 441—Chapter 119.

d. Optional service components. A member who elects the consumer choices option may purchase the following goods, services and supports, which shall be provided in the member's home or at an integrated community setting:

(1) Self-directed personal care services. Self-directed personal care services are services or goods that provide a range of assistance in activities of daily living and incidental activities of daily living that help the member remain in the home and community. These services must be identified in the member's service plan developed by the member's case manager or service worker.

(2) Self-directed community supports and employment. Self-directed community supports and employment are services that support the member in developing and maintaining independence and community integration. These services must be identified in the member's service plan developed by the member's case manager or service worker.

(3) Individual-directed goods and services. Individual-directed goods and services are services, equipment, or supplies not otherwise provided through the Medicaid program that address an assessed need or goal identified in the member's service plan. The item or service shall meet the following requirements:

1. Promote opportunities for community living and inclusion.
2. Increase independence or substitute for human assistance, to the extent the expenditures would otherwise be made for that human assistance.
3. Be accommodated within the member's budget without compromising the member's health and safety.
4. Be provided to the member or directed exclusively toward the benefit of the member.
5. Be the least costly to meet the member's needs.
6. Not be available through another source.

e. Development of the individual budget. The independent support broker shall assist the member in developing and implementing the member's individual budget. The individual budget shall include:

- (1) The costs of the financial management service.
- (2) The costs of the independent support broker. The independent support broker may be compensated for up to 6 hours of service for assisting with the implementation of the initial individual budget. The independent support broker shall not be paid for more than 30 hours of service for an individual member during a 12-month period without prior approval by the department.

(3) The costs of any optional service component chosen by the member as described in paragraph 78.43(15) "*d.*" Costs of the following items and services shall not be covered by the individual budget:

1. Child care services.
2. Clothing not related to an assessed medical need.
3. Conference, meeting or similar venue expenses other than the costs of approved services the member needs while attending the conference, meeting or similar venue.
4. Costs associated with shipping items to the member.
5. Experimental and non-FDA-approved medications, therapies, or treatments.
6. Goods or services covered by other Medicaid programs.
7. Home furnishings.
8. Home repairs or home maintenance.
9. Homeopathic treatments.
10. Insurance premiums or copayments.
11. Items purchased on installment payments.
12. Motorized vehicles.
13. Nutritional supplements.
14. Personal entertainment items.
15. Repairs and maintenance of motor vehicles.
16. Room and board, including rent or mortgage payments.
17. School tuition.
18. Service animals.

19. Services covered by third parties or services that are the responsibility of a non-Medicaid program.

20. Sheltered workshop services.

21. Social or recreational purchases not related to an assessed need or goal identified in the member's service plan.

22. Vacation expenses, other than the costs of approved services the member needs while on vacation.

(4) The costs of any approved home or vehicle modification or specialized medical equipment. When authorized, the budget may include an amount allocated for a home or vehicle modification or specialized medical equipment. Before becoming part of the individual budget, all home and vehicle modifications and specialized medical equipment shall be identified in the member's service plan and approved by the case manager or service worker. The authorized amount shall not be used for anything other than the specific modification or equipment.

(5) Any amount set aside in a savings plan to reserve funds for the future purchase of self-directed personal care, individual-directed goods and services, or self-directed community supports and services as defined in paragraph 78.43(15) "d." The savings plan shall meet the requirements in paragraph 78.43(15) "f."

f. Savings plan. A member savings plan must be in writing and be approved by the department before the start of the savings plan. Amounts allocated to the savings plan must result from efficiencies in meeting identified needs of the member.

(1) The savings plan shall identify:

1. The specific goods, services, supports or supplies to be purchased through the savings plan.

2. The amount of the individual budget allocated each month to the savings plan.

3. The amount of the individual budget allocated each month to meet the member's identified service needs.

4. How the member's assessed needs will continue to be met through the individual budget when funds are placed in savings.

(2) With the exception of funds allocated for respite care, the savings plan shall not include funds budgeted for direct services that were not received. The budgeted amount associated with unused direct services other than respite care shall revert to the Medicaid program at the end of each month. Funds from unused respite services may be allocated to the savings plan but shall not be used for anything other than future respite care.

(3) Funds accumulated under a savings plan shall be used only to purchase items that increase independence or substitute for human assistance to the extent that expenditures would otherwise be made for human assistance, including additional goods, supports, services or supplies. The self-directed personal care, individual-directed goods and services, or self-directed community supports and services purchased with funds from a savings plan must:

1. Be used to meet a member's identified need,

2. Be medically necessary, and

3. Be approved by the member's case manager or service worker.

(4) All funds allocated to a savings plan that are not expended by December 31 of each year shall revert to the Medicaid program.

(5) The annual reassessment of a member's needs must take into account the purchases of goods and services that substitute for human assistance. Adjustments shall be made to the services used to determine the individual budget based on the reassessment.

g. Budget authority. The member shall have authority over the individual budget authorized by the department to perform the following tasks:

(1) Contract with entities to provide services and supports as described in this subrule.

(2) Determine the amount to be paid for services. Reimbursement rates shall be consistent with rates paid by others in the community for the same or substantially similar services. Reimbursement rates for the independent support broker and the financial management service are subject to the limits in 441—subrule 79.1(2). The reimbursement rate for a member's legal representative who provides

services to the member as allowed by 441—paragraph 79.9(7) “b” must be based on the skill level of the legal representative and may not exceed the median statewide reimbursement rate for the service unless the higher rate receives prior approval from the department.

(3) Schedule the provision of services. Whenever a member’s legal representative provides services to the member as allowed by 441—paragraph 79.9(7) “b,” the legal representative may not be paid for more than 40 hours of service per week and a contingency plan must be established in the member’s service plan to ensure service delivery in the event the legal representative is unable to provide services due to illness or other unexpected event.

(4) Authorize payment for optional service components identified in the individual budget.

(5) Reallocate funds among services included in the budget. Every purchase of a good or service must be identified and approved in the individual budget before the purchase is made.

h. Delegation of budget authority. The member may delegate responsibility for the individual budget to a representative in addition to the independent support broker.

(1) The representative must be at least 18 years old.

(2) The representative shall not be a current provider of service to the member.

(3) The member shall sign a consent form that designates who the member has chosen as a representative and what responsibilities the representative shall have.

(4) The representative shall not be paid for this service.

i. Employer authority. The member shall have the authority to be the common-law employer of employees providing services and support under the consumer choices option. A common-law employer has the right to direct and control the performance of the services. The member may perform the following functions:

(1) Recruit employees.

(2) Select employees from a worker registry.

(3) Verify employee qualifications.

(4) Specify additional employee qualifications.

(5) Determine employee duties.

(6) Determine employee wages and benefits.

(7) Schedule employees.

(8) Train and supervise employees.

j. Employment agreement. Any person employed by the member to provide services under the consumer choices option shall sign an employment agreement with the member that outlines the employee’s and member’s responsibilities.

k. Responsibilities of the independent support broker. The independent support broker shall perform the following services as directed by the member or the member’s representative:

(1) Assist the member with developing the member’s initial and subsequent individual budgets and with making any changes to the individual budget.

(2) Have monthly contact with the member for the first four months of implementation of the initial individual budget and have quarterly contact thereafter.

(3) Complete the required employment packet with the financial management service.

(4) Assist with interviewing potential employees and entities providing services and supports if requested by the member.

(5) Assist the member with determining whether a potential employee meets the qualifications necessary to perform the job.

(6) Assist the member with obtaining a signed consent from a potential employee to conduct background checks if requested by the member.

(7) Assist the member with negotiating with entities providing services and supports if requested by the member.

(8) Assist the member with contracts and payment methods for services and supports if requested by the member.

(9) Assist the member with developing an emergency backup plan. The emergency backup plan shall address any health and safety concerns.

(10) Review expenditure reports from the financial management service to ensure that services and supports in the individual budget are being provided.

(11) Document in writing on the independent support broker timecard every contact the broker has with the member. Contact documentation shall include information on the extent to which the member's individual budget has addressed the member's needs and the satisfaction of the member.

l. Responsibilities of the financial management service. The financial management service shall perform all of the following services:

(1) Receive Medicaid funds in an electronic transfer.
(2) Process and pay invoices for approved goods and services included in the individual budget.
(3) Enter the individual budget into the Web-based tracking system chosen by the department and enter expenditures as they are paid.

(4) Provide real-time individual budget account balances for the member, the independent support broker, and the department, available at a minimum during normal business hours (9 a.m. to 5 p.m., Monday through Friday).

(5) Conduct criminal background checks on potential employees pursuant to 441—Chapter 119.

(6) Verify for the member an employee's citizenship or alien status.

(7) Assist the member with fiscal and payroll-related responsibilities including, but not limited to:

1. Verifying that hourly wages comply with federal and state labor rules.

2. Collecting and processing timecards.

3. Withholding, filing, and paying federal, state and local income taxes, Medicare and Social Security (FICA) taxes, and federal (FUTA) and state (SUTA) unemployment and disability insurance taxes, as applicable.

4. Computing and processing other withholdings, as applicable.

5. Processing all judgments, garnishments, tax levies, or other withholding on an employee's pay as may be required by federal, state, or local laws.

6. Preparing and issuing employee payroll checks.

7. Preparing and disbursing IRS Forms W-2 and W-3 annually.

8. Processing federal advance earned income tax credit for eligible employees.

9. Refunding over-collected FICA, when appropriate.

10. Refunding over-collected FUTA, when appropriate.

(8) Assist the member in completing required federal, state, and local tax and insurance forms.

(9) Establish and manage documents and files for the member and the member's employees.

(10) Monitor timecards, receipts, and invoices to ensure that they are consistent with the individual budget. Keep records of all timecards and invoices for each member for a total of five years.

(11) Provide to the department, the independent support broker, and the member monthly and quarterly status reports that include a summary of expenditures paid and amount of budget unused.

(12) Establish an accessible customer service system and a method of communication for the member and the independent support broker that includes alternative communication formats.

(13) Establish a customer services complaint reporting system.

(14) Develop a policy and procedures manual that is current with state and federal regulations and update as necessary.

(15) Develop a business continuity plan in the case of emergencies and natural disasters.

(16) Provide to the department an annual independent audit of the financial management service.

(17) Assist in implementing the state's quality management strategy related to the financial management service.

78.43(16) General service standards. All brain injury waiver services must be provided in accordance with the following standards:

a. Reimbursement shall not be available under the waiver for any services that the member can obtain as other nonwaiver Medicaid services or through any other funding source.

b. All services provided under the waiver must be delivered in the least restrictive environment possible and in conformity with the member's service plan.

c. Services must be billed in whole units.

- d.* For all services with a 15-minute unit of service, the following rounding process will apply:
 - (1) Add together the minutes spent on all billable activities during a calendar day for a daily total.
 - (2) For each day, divide the total minutes spent on billable activities by 15 to determine the number of full 15-minute units for that day.
 - (3) Round the remainder using these guidelines: Round 1 to 7 minutes down to zero units; round 8 to 14 minutes up to one unit.
 - (4) Add together the number of full units and the number of rounded units to determine the total number of units to bill for that day.

This rule is intended to implement Iowa Code section 249A.4.

[ARC 7957B, IAB 7/15/09, effective 7/1/09; ARC 9045B, IAB 9/8/10, effective 11/1/10; ARC 9403B, IAB 3/9/11, effective 5/1/11 (See Delay note at end of chapter); ARC 9704B, IAB 9/7/11, effective 9/1/11; ARC 9884B, IAB 11/30/11, effective 1/4/12; ARC 0191C, IAB 7/11/12, effective 7/1/12; ARC 0359C, IAB 10/3/12, effective 12/1/12; ARC 0707C, IAB 5/1/13, effective 7/1/13; ARC 0709C, IAB 5/1/13, effective 7/1/13; ARC 0842C, IAB 7/24/13, effective 7/1/13; ARC 1056C, IAB 10/2/13, effective 11/6/13; ARC 1071C, IAB 10/2/13, effective 10/1/13; ARC 1610C, IAB 9/3/14, effective 8/13/14]

441—78.44(249A) Lead inspection services. Payment shall be approved for lead inspection services. This service shall be provided for children who have had two venous blood lead levels of 15 to 19 micrograms per deciliter or one venous level greater than or equal to 20 micrograms per deciliter. This service includes, but is not limited to, X-ray fluorescence analyzer (XRF) readings, visual examination of paint, preventive education of the resident and homeowner, health education about lead poisoning, and a written report to the family, homeowner, medical provider, and local childhood lead poisoning prevention program.

This rule is intended to implement Iowa Code section 249A.4.

441—78.45(249A) Assertive community treatment. Assertive community treatment (ACT) services are comprehensive, integrated, and intensive outpatient services provided by a multidisciplinary team under the supervision of a psychiatrist. ACT services are directed toward the rehabilitation of behavioral, social, or emotional deficits or the amelioration of symptoms of a mental disorder. Most services are delivered in the member's home or another community setting.

78.45(1) Applicability. ACT services may be provided only to a member who meets all of the following criteria:

- a.* The member is at least 17 years old.
- b.* The member has a severe and persistent mental illness or complex mental health symptomatology. A severe and persistent mental illness is a psychiatric disorder that causes symptoms and impairments in basic mental and behavioral processes that produce distress and major functional disability in adult role functioning (such as social, personal, family, educational or vocational roles). Specifically, the member has a degree of impairment arising from a psychiatric disorder such that:
 - (1) The member does not have the resources or skills necessary to maintain an adequate level of functioning in the home or community environment without assistance or support;
 - (2) The member's judgment, impulse control, or cognitive perceptual abilities are compromised; and
 - (3) The member exhibits significant impairment in social, interpersonal, or familial functioning.
- c.* The member has a validated principal DSM-IV-TR Axis I diagnosis consistent with a severe and persistent mental illness. Members with a primary diagnosis of substance disorder, developmental disability, or organic disorder are not eligible for ACT services.
- d.* The member needs a consistent team of professionals and multiple mental health and support services to maintain the member in the community and reduce hospitalizations, as evidenced by:
 - (1) A pattern of repeated treatment failures with at least two hospitalizations within the previous 24 months, or
 - (2) A need for multiple or combined mental health and basic living supports to prevent the need for a more intrusive level of care.

e. The member presents a reasonable likelihood that ACT services will lead to specific, observable improvements in the member's functioning and assist the member in achieving or maintaining community tenure. Specifically, the member:

- (1) Is medically stable;
- (2) Does not require a level of care that includes more intensive medical monitoring;
- (3) Presents a low risk to self, others, or property, with treatment and support; and
- (4) Lives independently in the community or demonstrates a capacity to live independently and move from a dependent residential setting to independent living.

f. At the time of admission, the member has a comprehensive assessment that includes psychiatric history, medical history, work and educational history, substance use, problems with activities of daily living, social interests, and family relationships.

g. The member has a written treatment plan containing a work evaluation and the necessary psychiatric rehabilitation treatment and support services. The plan shall identify:

- (1) Treatment objectives and outcomes,
- (2) The expected frequency and duration of each service,
- (3) The location where the services will be provided,
- (4) A crisis plan, and
- (5) The schedule for updates of the treatment plan.

78.45(2) Services. The ACT team shall participate in all mental health services provided to the member and shall provide 24-hour service for the psychiatric needs of the member. Available ACT services are:

a. *Evaluation and medication management.*

(1) The evaluation portion of ACT services consists of a comprehensive mental health evaluation and assessment of the member by a psychiatrist, advanced registered nurse practitioner, or physician assistant.

(2) Medication management consists of the prescription and management of medication by a psychiatrist, advanced registered nurse practitioner, or physician assistant to respond to the member's complaints and symptoms. A psychiatric registered nurse assists in this management by contact with the member regarding medications and their effect on the member's complaints and symptoms.

b. *Integrated therapy and counseling for mental health and substance abuse.* This service consists of direct counseling for treatment of mental health and substance abuse symptoms by a psychiatrist, licensed mental health professional, advanced registered nurse practitioner, physician assistant, or substance abuse specialist. Individual counseling is provided by other team members under the supervision of a psychiatrist or licensed mental health practitioner.

c. *Skill teaching.* Skill teaching consists of side-by-side demonstration and observation of daily living activities by a registered nurse, licensed mental health professional, psychologist, substance abuse counselor, peer specialist, community support specialist, advanced registered nurse practitioner, or physician assistant.

d. *Community support.* Community support is provided by a licensed mental health professional, psychologist, substance abuse counselor, peer specialist, community support specialist, advanced registered nurse practitioner, or physician assistant. Community support consists of the following activities focused on recovery and rehabilitation:

(1) Personal and home skills training to assist the member to develop and maintain skills for self-direction and coping with the living situation.

(2) Community skills training to assist the member in maintaining a positive level of participation in the community through development of socialization skills and personal coping skills.

e. *Medication monitoring.* Medication monitoring services are provided by a psychiatric nurse and other team members under the supervision of a psychiatrist or psychiatric nurse and consist of:

- (1) Monitoring the member's day-to-day functioning, medication compliance, and access to medications; and
- (2) Ensuring that the member keeps appointments.

f. Case management for treatment and service plan coordination. Case management consists of the development by the ACT team of an individualized treatment and service plan, including personalized goals and outcomes, to address the member's medical symptoms and remedial functional impairments.

(1) Case management includes:

1. Assessments, referrals, follow-up, and monitoring.
2. Assisting the member in gaining access to necessary medical, social, educational, and other services.
3. Assessing the member to determine service needs by collecting relevant historical information through member records and other information from relevant professionals and natural supports.

(2) The team shall:

1. Develop a specific care plan based on the assessment of needs, including goals and actions to address the needed medical, social, educational, and other necessary services.
2. Make referrals to services and related activities to assist the member with the assessed needs.
3. Monitor and perform follow-up activities necessary to ensure that the plan is carried out and that the member has access to necessary services. Activities may include monitoring contacts with providers, family members, natural supports, and others.
4. Hold daily team meetings to facilitate ACT services and coordinate the member's care with other members of the team.

g. Crisis response. Crisis response consists of direct assessment and treatment of the member's urgent or crisis symptoms in the community by a registered nurse, licensed mental health professional, psychologist, substance abuse counselor, community support specialist, case manager, advanced registered nurse practitioner, or physician assistant, as appropriate.

h. Work-related services. Work-related services may be provided by a registered nurse, licensed mental health professional, psychologist, substance abuse counselor, community support specialist, case manager, advanced registered nurse practitioner, or physician assistant. Services consist of assisting the member in managing mental health symptoms as they relate to job performance. Services may include:

- (1) Collaborating with the member to look for job situations that may cause symptoms to increase and creating strategies to manage these situations.
- (2) Assisting the member to develop or enhance skills to obtain a work placement, such as individual work-related behavioral management.
- (3) Providing supports to maintain employment, such as crisis intervention related to employment.
- (4) Teaching communication, problem solving, and safety skills.
- (5) Teaching personal skills such as time management and appropriate grooming for employment.

This rule is intended to implement Iowa Code section 249A.4.

[ARC 9440B, IAB 4/6/11, effective 4/1/11]

441—78.46(249A) Physical disability waiver service. Payment shall be approved for the following services to members eligible for the HCBS physical disability waiver as established in 441—Chapter 83 and as identified in the member's service plan.

78.46(1) Consumer-directed attendant care service. Consumer-directed attendant care services are service activities performed by a person to help a member with self-care tasks which the member would typically do independently if the member were otherwise able. Covered service activities are limited to the nonskilled activities listed in paragraph 78.46(1)"f" and the skilled activities listed in paragraph 78.46(1)"g." Covered service activities must be essential to the health, safety, and welfare of the member. Services may be provided in the absence of a parent or guardian if the parent or guardian has given advance direction for the service provision.

a. Service planning.

(1) The member, parent, guardian, or attorney in fact under a durable power of attorney for health care shall:

1. Select the individual or agency that will provide the components of the attendant care services.

2. Determine with the selected provider what components of attendant care services the provider shall perform, subject to confirmation by the service worker or case manager that those components are consistent with the assessment and are authorized covered services.

3. Complete, sign, and date Form 470-3372, HCBS Consumer-Directed Attendant Care Agreement, to indicate the frequency, scope, and duration of services (a description of each service component and the time agreed on for that component). The case manager or service worker and provider shall also sign the agreement.

4. Submit the completed agreement to the service worker or case manager. The agreement shall be part of the member's service plan and shall be kept in the member's records, in the provider's records, and in the service worker's or case manager's records. Any service component that is not listed in the agreement shall not be payable.

(2) Whenever a legal representative acts as a provider of consumer-directed attendant care as allowed by 441—paragraph 79.9(7) “b,” the following shall apply:

1. The payment rate for the legal representative must be based on the skill level of the legal representative and may not exceed the median statewide reimbursement rate for the service unless the higher rate receives prior approval from the department;

2. The legal representative may not be paid for more than 40 hours of service per week; and

3. A contingency plan must be established in the member's service plan to ensure service delivery in the event the legal representative is unable to provide services due to illness or other unexpected event.

b. Supervision of skilled services. Skilled consumer-directed attendant care services shall be provided under the supervision of a licensed nurse or licensed therapist working under the direction of a physician. The licensed nurse or therapist shall:

(1) Retain accountability for actions that are delegated.

(2) Ensure appropriate assessment, planning, implementation, and evaluation.

(3) Make on-site supervisory visits every two weeks with the service provider present.

c. Service documentation. The consumer-directed attendant care provider must complete Form 470-4389, Consumer-Directed Attendant Care (CDAC) Service Record, for each day of service. Any service component that is not documented in accordance with rule 441—79.3(249A) shall not be payable.

d. Role of guardian or attorney. If the member has a guardian or attorney in fact under a durable power of attorney for health care:

(1) The service worker's or case manager's service plan shall address how consumer-directed attendant care services will be monitored to ensure that the member's needs are being adequately met. If the guardian or attorney in fact is the service provider, the service plan shall address how the service worker or case manager shall oversee service provision.

(2) The guardian or attorney in fact shall sign the claim form in place of the member, indicating that the service has been provided as presented on the claim.

e. Service units and billing. A unit of service is 15 minutes provided by an individual or agency. Each service shall be billed in whole units.

f. Nonskilled services. Covered nonskilled service activities are limited to help with the following activities:

(1) Dressing.

(2) Bathing, shampooing, hygiene, and grooming.

(3) Access to and from bed or a wheelchair, transferring, ambulation, and mobility in general.

(4) Toileting, including bowel, bladder, and catheter assistance (emptying the catheter bag, collecting a specimen, and cleaning the external area around the catheter).

(5) Meal preparation, cooking, and assistance with feeding, not including the cost of meals themselves. Meal preparation and cooking shall be provided only in the member's home.

(6) Housekeeping, laundry, and shopping essential to the member's health care at home.

(7) Taking medications ordinarily self-administered, including those ordered by a physician or other qualified health care provider.

(8) Minor wound care.

(9) Going to or returning from a place of employment and job-related tasks while the member is on the job site. Transportation for the member and assistance with understanding or performing the essential job functions are not included in consumer-directed attendant care services.

(10) Tasks, such as financial management and scheduling, that require cognitive or physical assistance.

(11) Communication essential to the health and welfare of the member, through interpreting and reading services and use of assistive devices for communication.

(12) Using transportation essential to the health and welfare of the member. The cost of the transportation is not included.

g. Skilled services. Covered skilled service activities are limited to help with the following activities:

(1) Tube feedings of members unable to eat solid foods.

(2) Intravenous therapy administered by a registered nurse.

(3) Parenteral injections required more than once a week.

(4) Catheterizations, continuing care of indwelling catheters with supervision of irrigations, and changing of Foley catheters when required.

(5) Respiratory care including inhalation therapy and tracheotomy care or tracheotomy care and ventilator.

(6) Care of decubiti and other ulcerated areas, noting and reporting to the nurse or therapist.

(7) Rehabilitation services including, but not limited to, bowel and bladder training, range of motion exercises, ambulation training, restorative nursing services, respiratory care and breathing programs, reality orientation, reminiscing therapy, remotivation, behavior modification, and reteaching of the activities of daily living.

(8) Colostomy care.

(9) Care of uncontrolled medical conditions, such as brittle diabetes, and comfort care of terminal conditions.

(10) Postsurgical nursing care.

(11) Monitoring medications requiring close supervision because of fluctuating physical or psychological conditions, e.g., antihypertensives, digitalis preparations, mood-altering or psychotropic drugs, or narcotics.

(12) Preparing and monitoring response to therapeutic diets.

(13) Recording and reporting of changes in vital signs to the nurse or therapist.

h. Excluded services and costs. Services, activities, costs and time that are not covered as consumer-directed attendant care include the following (not an exclusive list):

(1) Any activity related to supervising a member. Only direct services are billable.

(2) Any activity that the member is able to perform.

(3) Costs of food.

(4) Costs for the supervision of skilled services by the nurse or therapist. The supervising nurse or therapist may be paid from private insurance, Medicare, or other third-party payment sources, or may be paid as another Medicaid service, including early and periodic screening, diagnosis and treatment services.

(5) Exercise that does not require skilled services.

(6) Parenting or child care for or on behalf of the member.

(7) Reminders and cueing.

(8) Services provided simultaneously with any other similar service regardless of funding source, including other waiver services and state supplementary assistance in-home health-related care services.

(9) Transportation costs.

(10) Wait times for any activity.

78.46(2) Home and vehicle modification. Covered home or vehicle modifications are physical modifications to the member's home or vehicle that directly address the member's medical or remedial need. Covered modifications must be necessary to provide for the health, welfare, or safety of the member and enable the member to function with greater independence in the home or vehicle.

a. Modifications that are necessary or desirable without regard to the member's medical or remedial need and that would be expected to increase the fair market value of the home or vehicle, such as furnaces, fencing, or adding square footage to the residence, are excluded except as specifically included below. Purchasing or leasing of a motorized vehicle is excluded. Home and vehicle repairs are also excluded.

b. Only the following modifications are covered:

- (1) Kitchen counters, sink space, cabinets, special adaptations to refrigerators, stoves, and ovens.
- (2) Bathtubs and toilets to accommodate transfer, special handles and hoses for shower heads, water faucet controls, and accessible showers and sink areas.
- (3) Grab bars and handrails.
- (4) Turnaround space adaptations.
- (5) Ramps, lifts, and door, hall and window widening.
- (6) Fire safety alarm equipment specific for disability.
- (7) Voice-activated, sound-activated, light-activated, motion-activated, and electronic devices directly related to the member's disability.
- (8) Vehicle lifts, driver-specific adaptations, remote-start systems, including such modifications already installed in a vehicle.
- (9) Keyless entry systems.
- (10) Automatic opening device for home or vehicle door.
- (11) Special door and window locks.
- (12) Specialized doorknobs and handles.
- (13) Plexiglas replacement for glass windows.
- (14) Modification of existing stairs to widen, lower, raise or enclose open stairs.
- (15) Motion detectors.
- (16) Low-pile carpeting or slip-resistant flooring.
- (17) Telecommunications device for the deaf.
- (18) Exterior hard-surface pathways.
- (19) New door opening.
- (20) Pocket doors.
- (21) Installation or relocation of controls, outlets, switches.
- (22) Air conditioning and air filtering if medically necessary.
- (23) Heightening of existing garage door opening to accommodate modified van.
- (24) Bath chairs.

c. A unit of service is the completion of needed modifications or adaptations.

d. All modifications and adaptations shall be provided in accordance with applicable federal, state, and local building and vehicle codes.

e. Services shall be performed following prior department approval of the modification as specified in 441—subrule 79.1(17) and a binding contract between the provider and the member.

f. All contracts for home or vehicle modification shall be awarded through competitive bidding. The contract shall include the scope of work to be performed, the time involved, supplies needed, the cost, diagrams of the project whenever applicable, and an assurance that the provider has liability and workers' compensation coverage and the applicable permit and license.

g. Service payment shall be made to the enrolled home or vehicle modification provider. If applicable, payment will be forwarded to the subcontracting agency by the enrolled home or vehicle modification provider following completion of the approved modifications. Payment of up to \$6,366.64 per year may be made to certified providers upon satisfactory completion of the service. The case manager or service worker shall encumber a portion of the cost of a modification every month within the monthly dollar cap allowed for the member until the entire cost of the modification is encumbered within a consecutive 12-month period.

h. Services shall be included in the member's service plan and shall exceed the Medicaid state plan services.

78.46(3) *Personal emergency response or portable locator system.*

a. A personal emergency response system is an electronic device that transmits a signal to a central monitoring station to summon assistance in the event of an emergency.

(1) The necessary components of a system are:

1. An in-home medical communications transceiver.
2. A remote, portable activator.
3. A central monitoring station with backup systems staffed by trained attendants at all times.
4. Current data files at the central monitoring station containing response protocols and personal, medical, and emergency information for each member.

(2) The service shall be identified in the member's service plan.

(3) A unit of service is a one-time installation fee or one month of service.

(4) Maximum units per state fiscal year shall be the initial installation and 12 months of service.

b. A portable locator system is an electronic device that transmits a signal to a monitoring device. The system allows a member to access assistance in the event of an emergency and allows law enforcement or the monitoring system provider to locate a member who is unable to request help or to activate a system independently. The member must be unable to access assistance in an emergency situation due to the member's age or disability.

(1) The required components of the portable locator system are:

1. A portable communications transceiver or transmitter to be worn or carried by the member.
2. Monitoring by the provider at a central location with response protocols and personal, medical, and emergency information for each member as applicable.

(2) The service shall be identified in the member's service plan.

(3) Payable units of service are purchase of equipment, an installation or set-up fee, and monthly fees.

(4) Maximum units per state fiscal year shall be one equipment purchase, one installation or set-up fee, and 12 months of service.

78.46(4) *Specialized medical equipment.*

a. Specialized medical equipment shall include medically necessary items which are for personal use by members with a physical disability and which:

- (1) Provide for the health and safety of the member,
- (2) Are not ordinarily covered by Medicaid,
- (3) Are not funded by educational or vocational rehabilitation programs, and
- (4) Are not provided by voluntary means.

b. Coverage includes, but is not limited to:

- (1) Electronic aids and organizers.
- (2) Medicine dispensing devices.
- (3) Communication devices.
- (4) Bath aids.
- (5) Noncovered environmental control units.
- (6) Repair and maintenance of items purchased through the waiver.

c. Payment of up to \$6,060 per year may be made to enrolled specialized medical equipment providers upon satisfactory receipt of the service. Each month within the 12-month period, the service worker shall encumber an amount within the monthly dollar cap allowed for the member until the amount of the equipment cost is reached.

d. The need for specialized medical equipment shall be:

- (1) Documented by a health care professional as necessary for the member's health and safety, and
- (2) Identified in the member's service plan.

e. Payment for most items shall be based on a fee schedule. The amount of the fee shall be determined as directed in 441—subrule 79.1(17).

78.46(5) *Transportation.* Transportation services may be provided for members to conduct business errands and essential shopping, to receive medical services when not reimbursed through nonemergency

medical transportation, to travel to and from work or day programs, and to reduce social isolation. A unit of service is one mile of transportation or one one-way trip.

78.46(6) Consumer choices option. The consumer choices option provides a member with a flexible monthly individual budget that is based on the member's service needs. With the individual budget, the member shall have the authority to purchase goods and services to meet the member's assessed needs and may choose to employ providers of services and supports. The services, supports, and items that are purchased with an individual budget must be directly related to a member's assessed need or goal established in the member's service plan. Components of this service are set forth below.

a. Agreement. As a condition of participating in the consumer choices option, a member shall sign Form 470-4289, HCBS Consumer Choices Informed Consent and Risk Agreement, to document that the member has been informed of the responsibilities and risks of electing the consumer choices option.

b. Individual budget amount. A monthly individual budget amount shall be established for each member based on the assessed needs of the member and on the services and supports authorized in the member's service plan. The member shall be informed of the individual budget amount during the development of the service plan.

(1) Services that may be included in determining the individual budget amount for a member in the HCBS physical disability waiver are:

1. Consumer-directed attendant care (unskilled).
2. Home and vehicle modification.
3. Specialized medical equipment.
4. Transportation.

(2) The department shall determine an average unit cost for each service listed in subparagraph 78.46(6) "b"(1) based on actual unit costs from the previous fiscal year plus a cost-of-living adjustment.

(3) In aggregate, costs for individual budget services shall not exceed the current costs of waiver program services. In order to maintain cost neutrality, the department shall apply a utilization adjustment factor to the amount of service authorized in the member's service plan before calculating the value of that service to be included in the individual budget amount.

(4) The department shall compute the utilization adjustment factor for each service by dividing the net costs of all claims paid for the service by the total of the authorized costs for that service, using at least 12 consecutive months of aggregate service data. The utilization adjustment factor shall be no lower than 60 percent. The department shall analyze and adjust the utilization adjustment factor at least annually in order to maintain cost neutrality.

(5) Individual budgets for respite services shall be computed based on the average cost for services identified in subparagraph 78.46(6) "b"(2). Respite services are not subject to the utilization adjustment factor in subparagraph 78.46(6) "b"(3).

(6) Anticipated costs for home and vehicle modification and specialized medical equipment are not subject to the average cost in subparagraph 78.46(6) "b"(2) or the utilization adjustment factor in subparagraph 78.46(6) "b"(3). Anticipated costs for home and vehicle modification and specialized medical equipment shall not include the costs of the financial management services or the independent support broker. Before becoming part of the individual budget, all home and vehicle modifications and specialized medical equipment shall be identified in the member's service plan and approved by the case manager or service worker. Costs for home and vehicle modification and specialized medical equipment may be paid to the financial management services provider in a one-time payment.

(7) The individual budget amount may be changed only at the first of the month and shall remain fixed for the entire month.

c. Required service components. To participate in the consumer choices option, a member must hire an independent support broker and must work with a financial management service that is enrolled as a Medicaid provider. Before hiring the independent support broker, the member shall receive the results of the background check conducted pursuant to 441—Chapter 119.

d. Optional service components. A member who elects the consumer choices option may purchase the following goods, services and supports, which shall be provided in the member's home or at an integrated community setting:

(1) Self-directed personal care services. Self-directed personal care services are services or goods that provide a range of assistance in activities of daily living and incidental activities of daily living that help the member remain in the home and community. These services must be identified in the member's service plan developed by the member's case manager or service worker.

(2) Self-directed community supports and employment. Self-directed community supports and employment are services that support the member in developing and maintaining independence and community integration. These services must be identified in the member's service plan developed by the member's case manager or service worker.

(3) Individual-directed goods and services. Individual-directed goods and services are services, equipment, or supplies not otherwise provided through the Medicaid program that address an assessed need or goal identified in the member's service plan. The item or service shall meet the following requirements:

1. Promote opportunities for community living and inclusion.
2. Increase independence or substitute for human assistance, to the extent the expenditures would otherwise be made for that human assistance.
3. Be accommodated within the member's budget without compromising the member's health and safety.

4. Be provided to the member or directed exclusively toward the benefit of the member.

5. Be the least costly to meet the member's needs.

6. Not be available through another source.

e. Development of the individual budget. The independent support broker shall assist the member in developing and implementing the member's individual budget. The individual budget shall include:

- (1) The costs of the financial management service.

- (2) The costs of the independent support broker. The independent support broker may be compensated for up to 6 hours of service for assisting with the implementation of the initial individual budget. The independent support broker shall not be paid for more than 30 hours of service for an individual member during a 12-month period without prior approval by the department.

- (3) The costs of any optional service component chosen by the member as described in paragraph 78.46(6) "d." Costs of the following items and services shall not be covered by the individual budget:

1. Child care services.
2. Clothing not related to an assessed medical need.
3. Conference, meeting or similar venue expenses other than the costs of approved services the member needs while attending the conference, meeting or similar venue.
4. Costs associated with shipping items to the member.
5. Experimental and non-FDA-approved medications, therapies, or treatments.
6. Goods or services covered by other Medicaid programs.
7. Home furnishings.
8. Home repairs or home maintenance.
9. Homeopathic treatments.
10. Insurance premiums or copayments.
11. Items purchased on installment payments.
12. Motorized vehicles.
13. Nutritional supplements.
14. Personal entertainment items.
15. Repairs and maintenance of motor vehicles.
16. Room and board, including rent or mortgage payments.
17. School tuition.
18. Service animals.
19. Services covered by third parties or services that are the responsibility of a non-Medicaid program.
20. Sheltered workshop services.

21. Social or recreational purchases not related to an assessed need or goal identified in the member's service plan.

22. Vacation expenses, other than the costs of approved services the member needs while on vacation.

(4) The costs of any approved home or vehicle modification or specialized medical equipment. When authorized, the budget may include an amount allocated for a home or vehicle modification or specialized medical equipment. Before becoming part of the individual budget, all home and vehicle modifications and specialized medical equipment shall be identified in the member's service plan and approved by the case manager or service worker. The authorized amount shall not be used for anything other than the specific modification or equipment.

(5) Any amount set aside in a savings plan to reserve funds for the future purchase of self-directed personal care, individual-directed goods and services, or self-directed community supports and services as defined in paragraph 78.46(6) "d." The savings plan shall meet the requirements in paragraph 78.46(6) "f."

f. Savings plan. A member savings plan must be in writing and be approved by the department before the start of the savings plan. Amounts allocated to the savings plan must result from efficiencies in meeting identified needs of the member.

(1) The savings plan shall identify:

1. The specific goods, services, supports or supplies to be purchased through the savings plan.

2. The amount of the individual budget allocated each month to the savings plan.

3. The amount of the individual budget allocated each month to meet the member's identified service needs.

4. How the member's assessed needs will continue to be met through the individual budget when funds are placed in savings.

(2) With the exception of funds allocated for respite care, the savings plan shall not include funds budgeted for direct services that were not received. The budgeted amount associated with unused direct services other than respite care shall revert to the Medicaid program at the end of each month. Funds from unused respite services may be allocated to the savings plan but shall not be used for anything other than future respite care.

(3) Funds accumulated under a savings plan shall be used only to purchase items that increase independence or substitute for human assistance to the extent that expenditures would otherwise be made for human assistance, including additional goods, supports, services or supplies. The self-directed personal care, individual-directed goods and services, or self-directed community supports and services purchased with funds from a savings plan must:

1. Be used to meet a member's identified need,

2. Be medically necessary, and

3. Be approved by the member's case manager or service worker.

(4) All funds allocated to a savings plan that are not expended by December 31 of each year shall revert to the Medicaid program.

(5) The annual reassessment of a member's needs must take into account the purchases of goods and services that substitute for human assistance. Adjustments shall be made to the services used to determine the individual budget based on the reassessment.

g. Budget authority. The member shall have authority over the individual budget authorized by the department to perform the following tasks:

(1) Contract with entities to provide services and supports as described in this subrule.

(2) Determine the amount to be paid for services. Reimbursement rates shall be consistent with rates paid by others in the community for the same or substantially similar services. Reimbursement rates for the independent support broker and the financial management service are subject to the limits in 441—subrule 79.1(2). The reimbursement rate for a member's legal representative who provides services to the member as allowed by 441—paragraph 79.9(7) "b" must be based on the skill level of the legal representative and may not exceed the median statewide reimbursement rate for the service unless the higher rate receives prior approval from the department.

(3) Schedule the provision of services. Whenever a member's legal representative provides services to the member as allowed by 441—paragraph 79.9(7) “b,” the legal representative may not be paid for more than 40 hours of service per week and a contingency plan must be established in the member's service plan to ensure service delivery in the event the legal representative is unable to provide services due to illness or other unexpected event.

(4) Authorize payment for waiver goods and services optional service components identified in the individual budget.

(5) Reallocate funds among services included in the budget. Every purchase of a good or service must be identified and approved in the individual budget before the purchase is made.

h. Delegation of budget authority. The member may delegate responsibility for the individual budget to a representative in addition to the independent support broker.

(1) The representative must be at least 18 years old.

(2) The representative shall not be a current provider of service to the member.

(3) The member shall sign a consent form that designates who the member has chosen as a representative and what responsibilities the representative shall have.

(4) The representative shall not be paid for this service.

i. Employer authority. The member shall have the authority to be the common-law employer of employees providing services and support under the consumer choices option. A common-law employer has the right to direct and control the performance of the services. The member may perform the following functions:

(1) Recruit employees.

(2) Select employees from a worker registry.

(3) Verify employee qualifications.

(4) Specify additional employee qualifications.

(5) Determine employee duties.

(6) Determine employee wages and benefits.

(7) Schedule employees.

(8) Train and supervise employees.

j. Employment agreement. Any person employed by the member to provide services under the consumer choices option shall sign an employment agreement with the member that outlines the employee's and member's responsibilities.

k. Responsibilities of the independent support broker. The independent support broker shall perform the following services as directed by the member or the member's representative:

(1) Assist the member with developing the member's initial and subsequent individual budgets and with making any changes to the individual budget.

(2) Have monthly contact with the member for the first four months of implementation of the initial individual budget and have quarterly contact thereafter.

(3) Complete the required employment packet with the financial management service.

(4) Assist with interviewing potential employees and entities providing services and supports if requested by the member.

(5) Assist the member with determining whether a potential employee meets the qualifications necessary to perform the job.

(6) Assist the member with obtaining a signed consent from a potential employee to conduct background checks if requested by the member.

(7) Assist the member with negotiating with entities providing services and supports if requested by the member.

(8) Assist the member with contracts and payment methods for services and supports if requested by the member.

(9) Assist the member with developing an emergency backup plan. The emergency backup plan shall address any health and safety concerns.

(10) Review expenditure reports from the financial management service to ensure that services and supports in the individual budget are being provided.

(11) Document in writing on the independent support broker timecard every contact the broker has with the member. Contact documentation shall include information on the extent to which the member's individual budget has addressed the member's needs and the satisfaction of the member.

l. Responsibilities of the financial management service. The financial management service shall perform all of the following services:

- (1) Receive Medicaid funds in an electronic transfer.
- (2) Process and pay invoices for approved goods and services included in the individual budget.
- (3) Enter the individual budget into the Web-based tracking system chosen by the department and enter expenditures as they are paid.
- (4) Provide real-time individual budget account balances for the member, the independent support broker, and the department, available at a minimum during normal business hours (9 a.m. to 5 p.m., Monday through Friday).
- (5) Conduct criminal background checks on potential employees pursuant to 441—Chapter 119.
- (6) Verify for the member an employee's citizenship or alien status.
- (7) Assist the member with fiscal and payroll-related responsibilities including, but not limited to:
 1. Verifying that hourly wages comply with federal and state labor rules.
 2. Collecting and processing timecards.
 3. Withholding, filing, and paying federal, state and local income taxes, Medicare and Social Security (FICA) taxes, and federal (FUTA) and state (SUTA) unemployment and disability insurance taxes, as applicable.
 4. Computing and processing other withholdings, as applicable.
 5. Processing all judgments, garnishments, tax levies, or other withholding on an employee's pay as may be required by federal, state, or local laws.
 6. Preparing and issuing employee payroll checks.
 7. Preparing and disbursing IRS Forms W-2 and W-3 annually.
 8. Processing federal advance earned income tax credit for eligible employees.
 9. Refunding over-collected FICA, when appropriate.
 10. Refunding over-collected FUTA, when appropriate.
- (8) Assist the member in completing required federal, state, and local tax and insurance forms.
- (9) Establish and manage documents and files for the member and the member's employees.
- (10) Monitor timecards, receipts, and invoices to ensure that they are consistent with the individual budget. Keep records of all timecards and invoices for each member for a total of five years.
- (11) Provide to the department, the independent support broker, and the member monthly and quarterly status reports that include a summary of expenditures paid and amount of budget unused.
- (12) Establish an accessible customer service system and a method of communication for the member and the independent support broker that includes alternative communication formats.
- (13) Establish a customer services complaint reporting system.
- (14) Develop a policy and procedures manual that is current with state and federal regulations and update as necessary.
- (15) Develop a business continuity plan in the case of emergencies and natural disasters.
- (16) Provide to the department an annual independent audit of the financial management service.
- (17) Assist in implementing the state's quality management strategy related to the financial management service.

78.46(7) General service standards. All physical disability waiver services must be provided in accordance with the following standards:

- a.* Reimbursement shall not be available under the waiver for any services that the member can obtain as other nonwaiver Medicaid services or through any other funding source.
- b.* All services provided under the waiver must be delivered in the least restrictive environment possible and in conformity with the member's service plan.
- c.* Services must be billed in whole units.
- d.* For all services with a 15-minute unit of service, the following rounding process will apply:
 - (1) Add together the minutes spent on all billable activities during a calendar day for a daily total.

(2) For each day, divide the total minutes spent on billable activities by 15 to determine the number of full 15-minute units for that day.

(3) Round the remainder using these guidelines: Round 1 to 7 minutes down to zero units; round 8 to 14 minutes up to one unit.

(4) Add together the number of full units and the number of rounded units to determine the total number of units to bill for that day.

This rule is intended to implement Iowa Code section 249A.4.

[ARC 9045B, IAB 9/8/10, effective 11/1/10; ARC 9403B, IAB 3/9/11, effective 5/1/11; ARC 9704B, IAB 9/7/11, effective 9/1/11; ARC 9884B, IAB 11/30/11, effective 1/4/12; ARC 0707C, IAB 5/1/13, effective 7/1/13; ARC 0842C, IAB 7/24/13, effective 7/1/13; ARC 1056C, IAB 10/2/13, effective 11/6/13; ARC 1071C, IAB 10/2/13, effective 10/1/13; ARC 1610C, IAB 9/3/14, effective 8/13/14]

441—78.47(249A) Pharmaceutical case management services. Payment will be approved for pharmaceutical case management services provided by an eligible physician and pharmacist for Medicaid recipients determined to be at high risk for medication-related problems. These services are designed to identify, prevent, and resolve medication-related problems and improve drug therapy outcomes.

78.47(1) Medicaid recipient eligibility. Patients are eligible for pharmaceutical case management services if they have active prescriptions for four or more regularly scheduled nontopical medications, are ambulatory, do not reside in a nursing facility, and have at least one of the eligible disease states of congestive heart disease, ischemic heart disease, diabetes mellitus, hypertension, hyperlipidemia, asthma, depression, atrial fibrillation, osteoarthritis, gastroesophageal reflux, or chronic obstructive pulmonary disease.

78.47(2) Provider eligibility. Physicians and pharmacists shall meet the following criteria to provide pharmaceutical case management services.

a. Physicians and pharmacists must be enrolled in the Iowa Medicaid program, have an Iowa Medicaid provider number, and receive training under the direction of the department regarding the provision of pharmaceutical case management services under the Iowa Medicaid program.

A copy of pharmaceutical case management records, including documentation of services provided, shall be maintained on file in each provider's facility and be made available for audit by the department on request.

b. Physicians shall be licensed to practice medicine.

c. Pharmacists shall present to the department evidence of competency including state licensure, submit five acceptable patient care plans, and have successfully completed professional training on patient-oriented, medication-related problem prevention and resolution. Pharmacists shall also maintain problem-oriented patient records, provide a private patient consultation area, and submit a statement indicating that the submitted patient care plans are representative of the pharmacists' usual patient care plans.

Acceptable professional training programs are:

(1) A doctor of pharmacy degree program.

(2) The Iowa Center for Pharmaceutical Care (ICPC) training program, which is a cooperative training initiative of the University of Iowa College of Pharmacy, Drake University College of Pharmacy and Health Sciences, and the Iowa Pharmacy Foundation.

(3) Other programs containing similar coursework and supplemental practice site evaluation and reengineering, approved by the department with input from a peer review advisory committee.

78.47(3) Services. Eligible patients may choose whether to receive the services. If patients elect to receive the services, they must receive the services from any eligible physician and pharmacist acting as a pharmaceutical case management (PCM) team. Usually the eligible physician and pharmacist will be the patient's primary physician and pharmacist. Pharmaceutical case management services are to be value-added services complementary to the basic medical services provided by the primary physician and pharmacist.

The PCM team shall provide the following services:

a. *Initial assessment.* The initial assessment shall consist of:

(1) A patient evaluation by the pharmacist, including:

1. Medication history;
2. Assessment of indications, effectiveness, safety, and compliance of medication therapy;
3. Assessment for the presence of untreated illness; and
4. Identification of medication-related problems such as unnecessary medication therapy, suboptimal medication selection, inappropriate compliance, adverse drug reactions, and need for additional medication therapy.

(2) A written report and recommendation from the pharmacist to the physician.

(3) A patient care action plan developed by the PCM team with the patient's agreement and implemented by the PCM team. Specific components of the action plan will vary based on patient needs and conditions but may include changes in medication regimen, focused patient or caregiver education, periodic assessment for changes in the patient's condition, periodic monitoring of the effectiveness of medication therapy, self-management training, provision of patient-specific educational and informational materials, compliance enhancement, and reinforcement of healthy lifestyles. An action plan must be completed for each initial assessment.

b. New problem assessments. These assessments are initiated when a new medication-related problem is identified. The action plan is modified and new components are implemented to address the new problem. This assessment may occur in the interim between scheduled follow-up assessments.

c. Problem follow-up assessments. These assessments are based on patient need and a problem identified by a prior assessment. The patient's status is evaluated at an appropriate interval. The effectiveness of the implemented action plan is determined and modifications are made as needed.

d. Preventive follow-up assessments. These assessments occur approximately every six months when no current medication-related problems have been identified in prior assessments. The patient is reassessed for newly developed medication-related problems and the action plan is reviewed.

This rule is intended to implement Iowa Code section 249A.4 and 2000 Iowa Acts, chapter 1228, section 9.

441—78.48(249A) Public health agencies. Payments will be made to local public health agencies on a fee schedule basis for providing vaccine and vaccine administration and testing for communicable disease. In order to be paid for the administration of a vaccine covered under the Vaccines for Children (VFC) Program, a public health agency must enroll in the VFC program. Payment for the vaccine will be approved only if the VFC program stock has been depleted.

This rule is intended to implement Iowa Code section 249A.4.

[ARC 0358C, IAB 10/3/12, effective 11/7/12]

441—78.49(249A) Infant and toddler program services. Subject to the following subrules, payment shall be made for medical services provided to Medicaid eligible children by infant and toddler program providers under the infants and toddlers with disabilities program administered by the Iowa Child Health Specialty Clinics and the departments of education, public health, and human services.

78.49(1) Covered services. Covered services include, but are not limited to, audiology, psychological evaluation and counseling, health and nursing services, nutrition services, occupational therapy services, physical therapy services, developmental services, speech-language services, vision services, case management, and medical transportation.

78.49(2) Case management services. Payment shall also be approved for infant and toddler case management services subject to the following requirements:

a. Definition. "Case management" means services that will assist eligible children in gaining access to needed medical, social, educational, and other services. Case management is intended to address the complexities of coordinated service delivery for children with medical needs. The case manager should be the focus for coordinating and overseeing the effectiveness of all providers and programs in responding to the assessed need. Case management does not include the direct delivery of an underlying medical, educational, social, or other service to which an eligible child has been referred or any activities that are an integral part or an extension of the direct services.

b. Choice of provider. Children who also are eligible to receive targeted case management services under 441—Chapter 90 must choose whether to receive case management through the infant and toddler program or through 441—Chapter 90. The chosen provider must meet the requirements of this subrule.

(1) When a child resides in a medical institution, the institution is responsible for case management. The child is not eligible for any other case management services. However, noninstitutional case management services may be provided during the last 14 days before the child's planned discharge if the child's stay in the institution has been less than 180 consecutive days. If the child has been in the institution 180 consecutive days or longer, the child may receive noninstitutional case management services during the last 60 days before the child's planned discharge.

(2) If the case management agency also provides direct services, the case management unit must be designed so that conflict of interest is addressed and does not result in self-referrals.

(3) If the costs of any part of case management services are reimbursable under another program, the costs must be allocated between those programs and Medicaid in accordance with OMB Circular No. A-87 or any related or successor guidance or regulations regarding allocation of costs.

(4) The case manager must complete a competency-based training program with content related to knowledge and understanding of eligible children, Early ACCESS rules, the nature and scope of services in Early ACCESS, and the system of payments for services, as well as case management responsibilities and strategies. The department of education or its designee shall determine whether a person has successfully completed the training.

c. Assessment. The case manager shall conduct a comprehensive assessment and periodic reassessment of an eligible child to identify all of the child's service needs, including the need for any medical, educational, social, or other services. Assessment activities are defined to include the following:

- (1) Taking the child's history;
- (2) Identifying the needs of the child;
- (3) Gathering information from other sources, such as family members, medical providers, social workers, and educators, if necessary, to form a complete assessment of the child;
- (4) Completing documentation of the information gathered and the assessment results; and
- (5) Repeating the assessment every six months to determine whether the child's needs or preferences have changed.

d. Plan of care. The case manager shall develop a plan of care based on the information collected through the assessment or reassessment. The plan of care shall:

- (1) Include the child's strengths and preferences;
- (2) Consider the child's physical and social environment;
- (3) Specify goals of providing services to the child; and
- (4) Specify actions to address the child's medical, social, educational, and other service needs. These actions may include activities such as ensuring the active participation of the child and working with the child or the child's authorized health care decision maker and others to develop goals and identify a course of action to respond to the assessed needs of the child.

e. Other service components. Case management must include the following components:

(1) Contacts with the child and family. The case manager shall have face-to-face contact with the child and family within the first 30 days of service and every three months thereafter. In months in which there is no face-to-face contact, a telephone contact between the service coordinator and the family is required.

(2) Referral and related activities to help a child obtain needed services. The case manager shall help to link the child with medical, social, or educational providers or other programs and services that are capable of providing needed services. Referral activities do not include provision of the direct services, program, or activity to which the child has been linked. Referral activities include:

1. Assisting the family in gaining access to the infant and toddler program services and other services identified in the child's plan of care.
2. Assisting the family in identifying available service providers and funding resources and documenting unmet needs and gaps in services.

3. Making referrals to providers for needed services.
4. Scheduling appointments for the child.
5. Facilitating the timely delivery of services.
6. Arranging payment for medical transportation.

(3) Monitoring and follow-up activities. Monitoring activities shall take place at least once annually for the duration of the child's eligibility, but may be conducted as frequently as necessary to ensure that the plan of care is effectively implemented and adequately addresses the needs of the child. Monitoring and follow-up activities may be with the child, family members, providers, or other entities. The purpose of these activities is to help determine:

1. Whether services are being furnished in accordance with the child's plan of care.
2. Whether the services in the plan of care are adequate to meet the needs of the child.
3. Whether there are changes in the needs or status of the child. If there are changes in the child's needs or status, follow-up activities shall include making necessary adjustments to the plan of care and to service arrangements with providers.

(4) Keeping records, including preparing reports, updating the plan of care, making notes about plan activities in the child's record, and preparing and responding to correspondence with the family and others.

f. Documentation of case management. For each child receiving case management, case records must document:

- (1) The name of the child;
- (2) The dates of case management services;
- (3) The agency chosen by the family to provide the case management services;
- (4) The nature, content, and units of case management services received;
- (5) Whether the goals specified in the care plan have been achieved;
- (6) Whether the family has declined services in the care plan;
- (7) Time lines for providing services and reassessment; and
- (8) The need for and occurrences of coordination with case managers of other programs.

78.49(3) *Child's eligibility.* Payable services must be provided to a child under the age of 36 months who is experiencing developmental delay or who has a condition that is known to have a high probability of resulting in developmental delay at a later date.

78.49(4) *Delivery of services.* Services must be delivered directly by the infant and toddler program provider or by a practitioner under contract with the infant and toddler program provider.

78.49(5) *Remission of nonfederal share of costs.* Payment for services shall be made only when the following conditions are met:

- a.* Rescinded IAB 5/10/06, effective 7/1/06.
- b.* The infant and toddler program provider has executed an agreement to remit the nonfederal share of the cost to the department.
- c.* The infant and toddler program provider shall sign and return Form 470-3816, Medicaid Billing Remittance, along with the funds remitted for the nonfederal share of the costs of the services specified on the form.

This rule is intended to implement Iowa Code section 249A.4.

441—78.50(249A) Local education agency services. Subject to the following subrules, payment shall be made for medical services provided by local education agency services providers to Medicaid members under the age of 21.

78.50(1) *Covered services.* Covered services include, but are not limited to, audiology services, behavior services, consultation services, medical transportation, nursing services, nutrition services, occupational therapy services, personal assistance, physical therapy services, psychologist services, speech-language services, social work services, vision services, and school-based clinic visit services.

a. In order to be paid for the administration of a vaccine covered under the Vaccines for Children (VFC) Program, a local education agency must enroll in the VFC program. Payment for the vaccine will be approved only if the VFC program stock has been depleted.

b. Payment for supplies shall be approved when the supplies are incidental to the patient's care, e.g., syringes for injections, and do not exceed \$25 per month. Durable medical equipment and other supplies are not covered as local education agency services.

c. To the extent that federal funding is not available under Title XIX of the Social Security Act, payment for transportation between home and school is not a covered service.

78.50(2) Coordination services. Rescinded IAB 12/3/08, effective 2/1/09.

78.50(3) Delivery of services. Services must be delivered directly by the local education agency services providers or by a practitioner under contract with the local education agency services provider.

78.50(4) Remission of nonfederal share of costs. Payment for services shall be made only when the following conditions are met:

a. Rescinded IAB 5/10/06, effective 7/1/06.

b. The local education agency services provider has executed an agreement to remit the nonfederal share of the cost to the department.

c. The local education agency provider shall sign and return Form 470-3816, Medicaid Billing Remittance, along with the funds remitted for the nonfederal share of the costs of the services as specified on the form.

This rule is intended to implement Iowa Code section 249A.4.

[ARC 0065C, IAB 4/4/12, effective 6/1/12]

441—78.51(249A) Indian health service 638 facility services. Payment shall be made for all medically necessary services and supplies provided by a licensed practitioner at an Indian health service 638 facility, as defined at rule 441—77.45(249A), within the practitioner's scope of practice and subject to the limitations and exclusions set forth in subrule 78.1(1).

This rule is intended to implement Iowa Code section 249A.4.

441—78.52(249A) HCBS children's mental health waiver services. Payment will be approved for the following services to members eligible for the HCBS children's mental health waiver as established in 441—Chapter 83 and as identified in the member's service plan.

78.52(1) General service standards. All children's mental health waiver services must be provided in accordance with the following standards:

a. Reimbursement shall not be available under the waiver for any services that the member can obtain as other nonwaiver Medicaid services or through any other funding source.

b. All services provided under the waiver must be delivered in the least restrictive environment possible and in conformity with the member's service plan.

c. Services must be billed in whole units.

d. For all services with a 15-minute unit of service, the following rounding process will apply:

(1) Add together the minutes spent on all billable activities during a calendar day for a daily total.

(2) For each day, divide the total minutes spent on billable activities by 15 to determine the number of full 15-minute units for that day.

(3) Round the remainder using these guidelines: Round 1 to 7 minutes down to zero units; round 8 to 14 minutes up to one unit.

(4) Add together the number of full units and the number of rounded units to determine the total number of units to bill for that day.

78.52(2) Environmental modifications and adaptive devices.

a. Environmental modifications and adaptive devices include medically necessary items installed or used within the member's home that are used by the member to address specific, documented health, mental health, or safety concerns. The following items are excluded under this service:

(1) Items ordinarily covered by Medicaid.

(2) Items funded by educational or vocational rehabilitation programs.

(3) Items provided by voluntary means.

(4) Repair and maintenance of items purchased through the waiver.

(5) Fencing.

b. A unit of service is one modification or device.

c. For each unit of service provided, the case manager shall maintain in the member's case file a signed statement from a mental health professional on the member's interdisciplinary team that the service has a direct relationship to the member's diagnosis of serious emotional disturbance.

d. Payment for most items shall be based on a fee schedule. The amount of the fee shall be determined as directed in 441—subrule 79.1(17).

78.52(3) *Family and community support services.* Family and community support services shall support the member and the member's family by the development and implementation of strategies and interventions that will result in the reduction of stress and depression and will increase the member's and the family's social and emotional strength.

a. Dependent on the needs of the member and the member's family members individually or collectively, family and community support services may be provided to the member, to the member's family members, or to the member and the family members as a family unit.

b. Family and community support services shall be provided under the recommendation and direction of a mental health professional who is a member of the member's interdisciplinary team pursuant to 441—Chapter 83.

c. Family and community support services shall incorporate recommended support interventions and activities, which may include the following:

(1) Developing and maintaining a crisis support network for the member and for the member's family.

(2) Modeling and coaching effective coping strategies for the member's family members.

(3) Building resilience to the stigma of serious emotional disturbance for the member and the family.

(4) Reducing the stigma of serious emotional disturbance by the development of relationships with peers and community members.

(5) Modeling and coaching the strategies and interventions identified in the member's crisis intervention plan as defined in 441—24.1(225C) for life situations with the member's family and in the community.

(6) Developing medication management skills.

(7) Developing personal hygiene and grooming skills that contribute to the member's positive self-image.

(8) Developing positive socialization and citizenship skills.

d. Family and community support services may include an amount not to exceed \$1500 per member per year for transportation within the community and purchase of therapeutic resources. Therapeutic resources may include books, training materials, and visual or audio media.

(1) The interdisciplinary team must have identified the transportation or therapeutic resource as a support need and included that need in the case manager's plan.

(2) The annual amount available for transportation and therapeutic resources must be listed in the member's service plan.

(3) The member's parent or legal guardian shall submit a signed statement that the transportation or therapeutic resource cannot be provided by the member or the member's family or legal guardian.

(4) The member's Medicaid case manager shall maintain a signed statement that potential community resources are unavailable and shall list the community resources contacted to fund the transportation or therapeutic resource.

(5) The transportation or therapeutic resource must not be otherwise eligible for Medicaid reimbursement.

e. The following components are specifically excluded from family and community support services:

(1) Vocational services.

(2) Prevocational services.

(3) Supported employment services.

(4) Room and board.

- (5) Academic services.
- (6) General supervision and care.
- f. A unit of family and community support services is 15 minutes.

78.52(4) *In-home family therapy.* In-home family therapy provides skilled therapeutic services to the member and family that will increase their ability to cope with the effects of serious emotional disturbance on the family unit and the familial relationships. The service must support the family by the development of coping strategies that will enable the member to continue living within the family environment.

- a. The goal of in-home family therapy is to maintain a cohesive family unit.
- b. In-home family therapy is exclusive of and cannot serve as a substitute for individual therapy, family therapy, or other mental health therapy that may be obtained through the Iowa Plan or other funding sources.
- c. A unit of in-home family therapy service is 15 minutes.

78.52(5) *Respite care services.* Respite care services are services provided to the member that give temporary relief to the usual caregiver and provide all the necessary care that the usual caregiver would provide during that period. The purpose of respite care is to enable the member to remain in the member's current living situation.

- a. Respite services provided outside the member's home shall not be reimbursable if the living unit where respite care is provided is reserved for another person on a temporary leave of absence.
- b. Member-to-staff ratios shall be appropriate to the individual needs of the member as determined by the member's interdisciplinary team.
- c. A unit of service is 15 minutes.
- d. Respite care is not to be provided to members during the hours in which the usual caregiver is employed except when the member is attending a 24-hour residential camp. Respite care shall not be used as a substitute for a child's day care.
- e. The interdisciplinary team shall determine if the member will receive basic individual respite, specialized respite or group respite as defined in 441—Chapter 83.
- f. A maximum of 14 consecutive days of 24-hour respite care may be reimbursed.
- g. Respite services provided for a period exceeding 24 consecutive hours to three or more members who require nursing care because of a mental or physical condition must be provided by a health care facility licensed under Iowa Code chapter 135C.
- h. Respite services shall not be provided simultaneously with other residential, nursing, or home health aide services provided through the medical assistance program.

This rule is intended to implement Iowa Code section 249A.4 and 2005 Iowa Acts, chapter 167, section 13, and chapter 117, section 3.

[ARC 9403B, IAB 3/9/11, effective 5/1/11 (See Delay note at end of chapter); ARC 9704B, IAB 9/7/11, effective 9/1/11; ARC 9884B, IAB 11/30/11, effective 1/4/12; ARC 0707C, IAB 5/1/13, effective 7/1/13; ARC 0709C, IAB 5/1/13, effective 7/1/13]

441—78.53(249A) Health home services. Subject to federal approval in the Medicaid state plan, payment shall be made for health home services as described in subrule 78.53(1) provided to an eligible Medicaid member as described in subrule 78.53(2) who has selected a health home services provider as provided in subrule 78.53(3).

78.53(1) *Covered services.* Health home services consist of the following services provided in a comprehensive, timely, and high-quality manner using health information technology to link services, as feasible and appropriate:

- a. Comprehensive care management, which means:
 - (1) Providing for all the member's health care needs or taking responsibility for arranging care with other qualified professionals;
 - (2) Developing and maintaining for each member a continuity of care document that details all important aspects of the member's medical needs, treatment plan, and medication list; and
 - (3) Implementing a formal screening tool to assess behavioral health treatment needs and physical health care needs.

- b. Care coordination, which means assisting members with:
 - (1) Medication adherence;
 - (2) Chronic disease management;
 - (3) Appointments, referral scheduling, and reminders; and
 - (4) Understanding health insurance coverage.
- c. Health promotion, which means coordinating or providing behavior modification interventions aimed at:
 - (1) Supporting health management;
 - (2) Improving disease control; and
 - (3) Enhancing safety, disease prevention, and an overall healthy lifestyle.
- d. Comprehensive transitional care following a member's move from an inpatient setting to another setting. Comprehensive transitional care includes:
 - (1) Updates of the member's continuity of care document and case plan to reflect the member's short-term and long-term care coordination needs; and
 - (2) Personal follow-up with the member regarding all needed follow-up after the transition.
- e. Member and family support (including authorized representatives). This support may include:
 - (1) Communicating with and advocating for the member or family for the assessment of care decisions;
 - (2) Assisting with obtaining and adhering to medications and other prescribed treatments;
 - (3) Increasing health literacy and self-management skills; and
 - (4) Assessing the member's physical and social environment so that the plan of care incorporates needs, strengths, preferences, and risk factors.
- f. Referral to community and social support services available in the community.

78.53(2) Members eligible for health home services.

- a. Subject to the authority of the Secretary of the United States Department of Health and Human Services pursuant to 42 U.S.C. §1396w-4(h)(1)(B) to establish higher levels for the number or severity of chronic or mental health conditions for purposes of determining eligibility for receipt of health home services, payment shall be made only for health home services provided to a Medicaid member who:
 - (1) Has at least two chronic conditions;
 - (2) Has one chronic condition and is at risk of having a second chronic condition;
 - (3) Has a serious mental illness; or
 - (4) Has a serious emotional disturbance.
- b. For purposes of this rule, the term "chronic condition" means:
 - (1) A mental health disorder.
 - (2) A substance use disorder.
 - (3) Asthma.
 - (4) Diabetes.
 - (5) Heart disease.
 - (6) Being overweight, as evidenced by:
 - 1. Having a body mass index (BMI) over 25 for an adult, or
 - 2. Weighing over the 85th percentile for the pediatric population.
 - (7) Hypertension.
- c. For purposes of this rule, the term "serious mental illness" means:
 - (1) A psychotic disorder;
 - (2) Schizophrenia;
 - (3) Schizoaffective disorder;
 - (4) Major depression;
 - (5) Bipolar disorder;
 - (6) Delusional disorder; or
 - (7) Obsessive-compulsive disorder.
- d. For purposes of this rule, the term "serious emotional disturbance" means a diagnosable mental, behavioral, or emotional disorder (not including substance use disorders, learning disorders,

or intellectual disorders) that is of sufficient duration to meet diagnostic criteria specified in the most current Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association and that results in a functional impairment. For this purpose, the term “functional impairment” means episodic, recurrent, or continuous difficulties that substantially interfere with or limit a person from achieving or maintaining one or more developmentally appropriate social, behavioral, cognitive, communicative, or adaptive skills and that substantially interfere with or limit the person’s role or functioning in family, school, or community activities, not including difficulties resulting from temporary and expected responses to stressful events in a person’s environment.

78.53(3) *Selection of health home services provider.* As a condition of payment for health home services, the eligible member receiving the services must have selected the billing provider as the member’s health home, as reported by the provider. A member must select a provider located in the member’s county of residence or in a contiguous county.

This rule is intended to implement Iowa Code section 249A.4 and 2011 Iowa Acts, chapter 129, section 10.

[ARC 0198C, IAB 7/11/12, effective 7/1/12; ARC 0838C, IAB 7/24/13, effective 7/1/13]

441—78.54(249A) Speech-language pathology services. Payment will be approved for the same services provided by a speech-language pathologist that are payable under Title XVIII of the Social Security Act (Medicare).

This rule is intended to implement Iowa Code section 249A.4 and 2012 Iowa Acts, Senate File 2158. [ARC 0360C, IAB 10/3/12, effective 12/1/12]

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¹ Effective date of 78.3 and 78.31 delayed 70 days by the Administrative Rules Review Committee at its January 1, 1988 meeting.

² Effective date of 4/1/90 delayed 70 days by the Administrative Rules Review Committee at its March 12, 1990, meeting.

³ Effective date of 4/1/91 delayed until adjournment of the 1991 session of the General Assembly by the Administrative Rules Review Committee at its meeting held February 12, 1991.

- ⁴ Effective date of 3/1/92 delayed until adjournment of the 1992 General Assembly by the Administrative Rules Review Committee at its meeting held February 3, 1992.
- ⁵ At a special meeting held January 24, 2002, the Administrative Rules Review Committee voted to delay until adjournment of the 2002 Session of the General Assembly the effective date of amendments published in the February 6, 2002, Iowa Administrative Bulletin as **ARC 1365B**.
- ⁶ Effective date of 12/15/02 delayed 70 days by the Administrative Rules Review Committee at its December 10, 2002, meeting.
- ⁷ July 1, 2009, effective date of amendments to 78.27(2)“d” delayed 70 days by the Administrative Rules Review Committee at a special meeting held June 25, 2009.
- ⁸ May 11, 2011, effective date of 78.34(5)“d,” 78.38(5)“h,” 78.41(2)“g,” 78.43(3)“d,” and 78.52(5)“a” delayed 70 days by the Administrative Rules Review Committee at its meeting held April 11, 2011.

CHAPTER 79
OTHER POLICIES RELATING TO PROVIDERS OF
MEDICAL AND REMEDIAL CARE

[Prior to 7/1/83, Social Services[770] Ch 79]

441—79.1(249A) Principles governing reimbursement of providers of medical and health services. The basis of payment for services rendered by providers of services participating in the medical assistance program is either a system based on the provider's allowable costs of operation or a fee schedule. Generally, institutional types of providers such as hospitals and nursing facilities are reimbursed on a cost-related basis, and practitioners such as physicians, dentists, optometrists, and similar providers are reimbursed on the basis of a fee schedule. Providers of service must accept reimbursement based upon the department's methodology without making any additional charge to the member.

79.1(1) Types of reimbursement.

a. Prospective cost-related. Providers are reimbursed on the basis of a per diem rate calculated prospectively for each participating provider based on reasonable and proper costs of operation. The rate is determined by establishing a base year per diem rate to which an annual index is applied.

b. Retrospective cost-related. Providers are reimbursed on the basis of a per diem rate calculated retrospectively for each participating provider based on reasonable and proper costs of operation with suitable retroactive adjustments based on submission of financial and statistical reports by the provider. The retroactive adjustment represents the difference between the amount received by the provider during the year for covered services and the amount determined in accordance with an accepted method of cost apportionment (generally the Medicare principles of apportionment) to be the actual cost of service rendered medical assistance recipients.

c. Fee schedules. Fees for the various procedures involved are determined by the department with advice and consultation from the appropriate professional group. The fees are intended to reflect the amount of resources (time, training, experience) involved in each procedure. Individual adjustments will be made periodically to correct any inequity or to add new procedures or eliminate or modify others. If product cost is involved in addition to service, reimbursement is based either on a fixed fee, wholesale cost, or on actual acquisition cost of the product to the provider, or product cost is included as part of the fee schedule. Providers on fee schedules are reimbursed the lower of:

- (1) The actual charge made by the provider of service.
- (2) The maximum allowance under the fee schedule for the item of service in question.

Payment levels for fee schedule providers of service will be increased on an annual basis by an economic index reflecting overall inflation as well as inflation in office practice expenses of the particular provider category involved to the extent data is available. Annual increases will be made beginning July 1, 1988.

There are some variations in this methodology which are applicable to certain providers. These are set forth below in subrules 79.1(3) to 79.1(9) and 79.1(15).

Fee schedules in effect for the providers covered by fee schedules can be obtained from the department's Web site at: http://www.ime.state.ia.us/Reports_Publications/FeeSchedules.html.

d. Fee for service with cost settlement. Providers of case management services shall be reimbursed on the basis of a payment rate for a 15-minute unit of service based on reasonable and proper costs for service provision. The fee will be determined by the department with advice and consultation from the appropriate professional group and will reflect the amount of resources involved in service provision.

(1) Providers are reimbursed throughout each fiscal year on the basis of a projected unit rate for each participating provider. The projected rate is based on reasonable and proper costs of operation, pursuant to federally accepted reimbursement principles (generally Medicare or OMB A-87 principles).

(2) Payments are subject to annual retrospective cost settlement based on submission of actual costs of operation and service utilization data by the provider on Form 470-0664, Financial and Statistical Report. The cost settlement represents the difference between the amount received by the provider

during the year for covered services and the amount supported by the actual costs of doing business, determined in accordance with an accepted method of cost appointment.

(3) The methodology for determining the reasonable and proper cost for service provision assumes the following:

1. The indirect administrative costs shall be limited to 23 percent of other costs. Other costs include: professional staff – direct salaries, other – direct salaries, benefits and payroll taxes associated with direct salaries, mileage and automobile rental, agency vehicle expense, automobile insurance, and other related transportation.

2. Mileage shall be reimbursed at a rate no greater than the state employee rate.

3. The rates a provider may charge are subject to limits established at 79.1(2).

4. Costs of operation shall include only those costs that pertain to the provision of services which are authorized under rule 441—90.3(249A).

e. Retrospectively limited prospective rates. Providers are reimbursed on the basis of a rate for a unit of service calculated prospectively for each participating provider (and, for supported community living daily rates, for each consumer or site) based on projected or historical costs of operation subject to the maximums listed in subrule 79.1(2) and to retrospective adjustment pursuant to subparagraph 79.1(1)“e”(3).

- (1) The prospective rates for new providers who have not submitted six months of cost reports will be based on a projection of the provider’s reasonable and proper costs of operation until the provider has submitted an annual cost report that includes a minimum of six months of actual costs.

- (2) The prospective rates paid established providers who have submitted an annual report with a minimum of a six-month history are based on reasonable and proper costs in a base period and are adjusted annually for inflation.

- (3) The prospective rates paid to both new and established providers are subject to the maximums listed in subrule 79.1(2) and to retrospective adjustment based on the provider’s actual, current costs of operation as shown by financial and statistical reports submitted by the provider, so as not to exceed reasonable and proper costs actually incurred by more than 4.5 percent.

f. Contractual rate. Providers are reimbursed on a basis of costs incurred pursuant to a contract between the provider and subcontractor.

g. Retrospectively adjusted prospective rates. Critical access hospitals are reimbursed prospectively, with retrospective adjustments based on annual cost reports submitted by the hospital at the end of the hospital’s fiscal year. The retroactive adjustment equals the difference between the reasonable costs of providing covered services to eligible fee-for-service Medicaid members (excluding members in managed care), determined in accordance with Medicare cost principles, and the Medicaid reimbursement received. Amounts paid that exceed reasonable costs shall be recovered by the department. See paragraphs 79.1(5)“aa” and 79.1(16)“h.”

h. Indian health service 638 facilities. Indian health service 638 facilities as defined at rule 441—77.45(249A) are paid a special daily base encounter rate for all Medicaid-covered services rendered to American Indian or Alaskan native persons who are Medicaid-eligible. This rate is updated periodically and published in the Federal Register after being approved by the Office of Management and Budget. Indian health service 638 facilities may bill only one charge per patient per day for services provided to American Indians or Alaskan natives, which shall include all services provided on that day.

Services provided to Medicaid recipients who are not American Indians or Alaskan natives will be paid at the fee schedule allowed by Iowa Medicaid for the services provided and will be billed separately by CPT code on the CMS-1500 Health Insurance Claim Form. Claims for services provided to Medicaid recipients who are not American Indians or Alaskan natives must be submitted by the individual practitioner enrolled in the Iowa Medicaid program, but may be paid to the facility if the provider agreement so stipulates.

79.1(2) *Basis of reimbursement of specific provider categories.*

<u>Provider category</u>	<u>Basis of reimbursement</u>	<u>Upper limit</u>
Advanced registered nurse practitioners	Fee schedule	Fee schedule in effect 6/30/13 plus 1%.
Ambulance	Fee schedule	Ground ambulance: Fee schedule in effect 6/30/14 plus 10%. Air ambulance: Fee schedule in effect 6/30/14 plus 10%.
Ambulatory surgical centers	Base rate fee schedule as determined by Medicare. See 79.1(3)	Fee schedule in effect 6/30/13 plus 1%.
Area education agencies	Fee schedule	Fee schedule in effect 6/30/00 plus 0.7%.
Assertive community treatment	Fee schedule	\$51.08 per day for each day on which a team meeting is held. Maximum of 5 days per week.
Audiologists	Fee schedule	Fee schedule in effect 6/30/13 plus 1%.
Behavioral health intervention	Fee schedule as determined by the Iowa Plan for Behavioral Health	Fee schedule in effect 7/1/13.
Behavioral health services	Fee schedule	Fee schedule in effect 6/30/13 plus 1%.
Birth centers	Fee schedule	Fee schedule in effect 6/30/13 plus 1%.
Chiropractors	Fee schedule	Fee schedule in effect 6/30/13 plus 1%.
Clinics	Fee schedule	Maximum physician reimbursement rate.
Community mental health centers and providers of mental health services to county residents pursuant to a waiver approved under Iowa Code section 225C.7(3)	Retrospective cost-related. See 79.1(25)	100% of reasonable Medicaid cost as determined by Medicare cost reimbursement principles.
Dentists	Fee schedule	Fee schedule in effect 6/30/13 plus 1%.
Durable medical equipment, prosthetic devices and medical supply dealers	Fee schedule. See 79.1(4)	Fee schedule in effect 6/30/13 plus 1%.
Family planning clinics	Fee schedule	Fee schedule in effect 6/30/13 plus 1%.
Federally qualified health centers	Retrospective cost-related. See 441—88.14(249A)	1. Prospective payment rate as required by the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA 2000) or an alternative methodology allowed thereunder, as specified in “2” below. 2. 100% of reasonable cost as determined by Medicare cost reimbursement principles.

<u>Provider category</u>	<u>Basis of reimbursement</u>	<u>Upper limit</u>
HCBS waiver service providers, including:		3. In the case of services provided pursuant to a contract between an FQHC and a managed care organization (MCO), reimbursement from the MCO shall be supplemented to achieve "1" or "2" above.
		Except as noted, limits apply to all waivers that cover the named provider.
		Effective 7/1/13, for AIDS/HIV, brain injury, elderly, and ill and handicapped waivers: Provider's rate in effect 6/30/13 plus 3%, converted to a 15-minute, half-day, full-day, or extended-day rate. If no 6/30/13 rate: Veterans Administration contract rate or \$1.45 per 15-minute unit, \$23.24 per half day, \$46.26 per full day, or \$69.37 per extended day if no Veterans Administration contract.
1. Adult day care	Fee schedule	Effective 7/1/13, for intellectual disability waiver: County contract rate or, in the absence of a contract rate, provider's rate in effect 6/30/13 plus 3%, converted to a 15-minute, half-day, full-day, or extended-day rate. If no 6/30/13 rate, \$1.94 per 15-minute unit, \$30.96 per half day, \$61.80 per full day, or \$78.80 per extended day.
2. Emergency response system:		
Personal response system	Fee schedule	Effective 7/1/13, provider's rate in effect 6/30/13 plus 3%. If no 6/30/13 rate: Initial one-time fee: \$52.04. Ongoing monthly fee: \$40.47.
Portable locator system	Fee schedule	Effective 7/1/13, provider's rate in effect 6/30/13 plus 3%. If no 6/30/13 rate: One equipment purchase: \$323.26. Initial one-time fee: \$52.04. Ongoing monthly fee: \$40.47.

<u>Provider category</u>	<u>Basis of reimbursement</u>	<u>Upper limit</u>
3. Home health aides	Retrospective cost-related	For AIDS/HIV, elderly, and health and disability waivers effective 7/1/13: Lesser of maximum Medicare rate in effect 6/30/13 plus 3% or maximum Medicaid rate in effect 6/30/13 plus 3%.
		For intellectual disability waiver effective 7/1/13: Lesser of maximum Medicare rate in effect 6/30/13 plus 3% or maximum Medicaid rate in effect 6/30/13 plus 3%, converted to an hourly rate.
4. Homemakers	Fee schedule	Effective 7/1/13, provider's rate in effect 6/30/13 plus 3%, converted to a 15-minute rate. If no 6/30/13 rate: \$5.20 per 15-minute unit.
5. Nursing care	For elderly and intellectual disability waivers: Fee schedule as determined by Medicare.	For elderly waiver effective 7/1/13, provider's rate in effect 6/30/13 plus 3%. If no 6/30/13 rate: \$87.12 per visit.
		For intellectual disability waiver effective 7/1/13: Lesser of maximum Medicare rate in effect 6/30/13 plus 3% or maximum Medicaid rate in effect 6/30/13 plus 3%, converted to an hourly rate.
	For AIDS/HIV and health and disability waivers: Agency's financial and statistical cost report and Medicare percentage rate per visit.	For AIDS/HIV and health and disability waivers effective 7/1/13, provider's rate in effect 6/30/13 plus 3%. If no 6/30/13 rate: \$87.12 per visit.
6. Respite care when provided by: Home health agency: Specialized respite	Cost-based rate for nursing services provided by a home health agency	Effective 7/1/13, provider's rate in effect 6/30/13 plus 3%, converted to a 15-minute rate. If no 6/30/13 rate: Lesser of maximum Medicare rate in effect 6/30/13 plus 3%, converted to a 15-minute rate, or maximum Medicaid rate in effect 6/30/13 plus 3%, converted to a 15-minute rate, not to exceed \$311.97 per day.

<u>Provider category</u>	<u>Basis of reimbursement</u>	<u>Upper limit</u>
Basic individual respite	Cost-based rate for home health aide services provided by a home health agency	Effective 7/1/13, provider's rate in effect 6/30/13 plus 3%, converted to a 15-minute rate. If no 6/30/13 rate: Lesser of maximum Medicare rate in effect 6/30/13 plus 3%, converted to a 15-minute rate, or maximum Medicaid rate in effect 6/30/13 plus 3%, converted to a 15-minute rate, not to exceed \$311.97 per day.
Group respite	Fee schedule	Effective 7/1/13, provider's rate in effect 6/30/13 plus 3%, converted to a 15-minute rate. If no 6/30/13 rate: \$3.45 per 15-minute unit, not to exceed \$311.97 per day.
Home care agency:		
Specialized respite	Fee schedule	Effective 7/1/13, provider's rate in effect 6/30/13 plus 3%, converted to a 15-minute rate. If no 6/30/13 rate: \$8.87 per 15-minute unit, not to exceed \$311.97 per day.
Basic individual respite	Fee schedule	Effective 7/1/13, provider's rate in effect 6/30/13 plus 3%, converted to a 15-minute rate. If no 6/30/13 rate: \$4.73 per 15-minute unit, not to exceed \$311.97 per day.
Group respite	Fee schedule	Effective 7/1/13, provider's rate in effect 6/30/13 plus 3%, converted to a 15-minute rate. If no 6/30/13 rate: \$3.45 per 15-minute unit, not to exceed \$311.97 per day.
Nonfacility care:		
Specialized respite	Fee schedule	Effective 7/1/13, provider's rate in effect 6/30/13 plus 3%, converted to a 15-minute rate. If no 6/30/13 rate: \$8.87 per 15-minute unit, not to exceed \$311.97 per day.
Basic individual respite	Fee schedule	Effective 7/1/13, provider's rate in effect 6/30/13 plus 3%, converted to a 15-minute rate. If no 6/30/13 rate: \$4.73 per 15-minute unit, not to exceed \$311.97 per day.
Group respite	Fee schedule	Effective 7/1/13, provider's rate in effect 6/30/13 plus 3%, converted to a 15-minute rate. If no 6/30/13 rate: \$3.45 per 15-minute unit, not to exceed \$311.97 per day.

<u>Provider category</u>	<u>Basis of reimbursement</u>	<u>Upper limit</u>
Facility care:		
Hospital or nursing facility providing skilled care	Fee schedule	Effective 7/1/13, provider's rate in effect 6/30/13 plus 3%, converted to a 15-minute rate. If no 6/30/13 rate: \$3.45 per 15-minute unit, not to exceed the facility's daily Medicaid rate for skilled nursing level of care.
Nursing facility	Fee schedule	Effective 7/1/13, provider's rate in effect 6/30/13 plus 3%, converted to a 15-minute rate. If no 6/30/13 rate: \$3.45 per 15-minute unit, not to exceed the facility's daily Medicaid rate.
Camps	Fee schedule	Effective 7/1/13, provider's rate in effect 6/30/13 plus 3%, converted to a 15-minute rate. If no 6/30/13 rate: \$3.45 per 15-minute unit, not to exceed \$311.97 per day.
Adult day care	Fee schedule	Effective 7/1/13, provider's rate in effect 6/30/13 plus 3%, converted to a 15-minute rate. If no 6/30/13 rate: \$3.45 per 15-minute unit, not to exceed rate for regular adult day care services.
Intermediate care facility for persons with an intellectual disability	Fee schedule	Effective 7/1/13, provider's rate in effect 6/30/13 plus 3%, converted to a 15-minute rate. If no 6/30/13 rate: \$3.45 per 15-minute unit, not to exceed the facility's daily Medicaid rate.
Residential care facilities for persons with an intellectual disability	Fee schedule	Effective 7/1/13, provider's rate in effect 6/30/13 plus 3%, converted to a 15-minute rate. If no 6/30/13 rate: \$3.45 per 15-minute unit, not to exceed contractual daily rate.
Foster group care	Fee schedule	Effective 7/1/13, provider's rate in effect 6/30/13 plus 3%, converted to a 15-minute rate. If no 6/30/13 rate: \$3.45 per 15-minute unit, not to exceed daily rate for child welfare services.
Child care facilities	Fee schedule	Effective 7/1/13, provider's rate in effect 6/30/13 plus 3%, converted to a 15-minute rate. If no 6/30/13 rate: \$3.45 per 15-minute unit, not to exceed contractual daily rate.
7. Chore service	Fee schedule	Effective 7/1/13, provider's rate in effect 6/30/13 plus 3%, converted to a 15-minute rate. If no 6/30/13 rate: \$4.05 per 15-minute unit.

<u>Provider category</u>	<u>Basis of reimbursement</u>	<u>Upper limit</u>
8. Home-delivered meals	Fee schedule	Effective 7/1/13, provider's rate in effect 6/30/13 plus 3%. If no 6/30/13 rate: \$8.10 per meal. Maximum of 14 meals per week.
9. Home and vehicle modification	Fee schedule. See 79.1(17)	For elderly waiver effective 7/1/13: \$1,061.11 lifetime maximum. For intellectual disability waiver effective 7/1/13: \$5,305.53 lifetime maximum. For brain injury, health and disability, and physical disability waivers effective 7/1/13: \$6,366.64 per year.
10. Mental health outreach providers	Fee schedule	Effective 7/1/13, provider's rate in effect 6/30/13 plus 3%. If no 6/30/13 rate: On-site Medicaid reimbursement rate for center or provider. Maximum of 1,440 units per year.
11. Transportation	Fee schedule	Effective 10/1/13: The provider's nonemergency medical transportation contract rate or, in the absence of a nonemergency medical transportation contract rate, the median nonemergency medical transportation contract rate paid per mile or per trip within the member's DHS region.
12. Nutritional counseling	Fee schedule	Effective 7/1/13 for non-county contract: Provider's rate in effect 6/30/13 plus 3%, converted to a 15-minute rate. If no 6/30/13 rate: \$8.67 per 15-minute unit.
13. Assistive devices	Fee schedule. See 79.1(17)	Effective 7/1/13: \$115.62 per unit.
14. Senior companion	Fee schedule	Effective 7/1/13 for non-county contract: Provider's rate in effect 6/30/13 plus 3%, converted to a 15-minute rate. If no 6/30/13 rate: \$1.87 per 15-minute unit.
15. Consumer-directed attendant care provided by:		
Agency (other than an elderly waiver assisted living program)	Fee agreed upon by member and provider	Effective 7/1/13, provider's rate in effect 6/30/13 plus 3%, converted to a 15-minute rate. If no 6/30/13 rate: \$5.30 per 15-minute unit, not to exceed \$122.62 per day.

<u>Provider category</u>	<u>Basis of reimbursement</u>	<u>Upper limit</u>
Assisted living program (for elderly waiver only)	Fee agreed upon by member and provider	Effective 7/1/13, provider's rate in effect 6/30/13 plus 3%, converted to a 15-minute rate. If no 6/30/13 rate: \$5.30 per 15-minute unit, not to exceed \$122.62 per day.
Individual	Fee agreed upon by member and provider	Effective 7/1/13, \$3.54 per 15-minute unit, not to exceed \$82.53 per day. When an individual who serves as a member's legal representative provides services to the member as allowed by 79.9(7) "b," the payment rate must be based on the skill level of the legal representative and may not exceed the median statewide reimbursement rate for the service unless the higher rate receives prior approval from the department.
16. Counseling:		
Individual	Fee schedule	Effective 7/1/13, provider's rate in effect 6/30/13 plus 3%, converted to a 15-minute rate. If no 6/30/13 rate: \$11.34 per 15-minute unit.
Group	Fee schedule	Effective 7/1/13, provider's rate in effect 6/30/13 plus 3%, converted to a 15-minute rate. If no 6/30/13 rate: \$11.33 per 15-minute unit. Rate is divided by six, or, if the number of persons who comprise the group exceeds six, the actual number of persons who comprise the group.
17. Case management	Fee for service with cost settlement. See 79.1(1) "d."	For brain injury and elderly waivers: Retrospective cost-settled rate.
18. Supported community living	Retrospectively limited prospective rates. See 79.1(15)	For intellectual disability and brain injury waiver effective 7/1/13: \$9.19 per 15-minute unit, not to exceed the maximum daily ICF/ID rate per day plus 3%.
19. Supported employment:		
Activities to obtain a job:		
Job development	Fee schedule	Effective 7/1/13, provider's rate in effect 6/30/13 plus 3%. If no 6/30/13 rate: \$955.00 per unit (job placement). Maximum of two units per 12 months.
Employer development	Fee schedule	Effective 7/1/13, provider's rate in effect 6/30/13 plus 3%. If no 6/30/13 rate: \$955.00 per unit (job placement). Maximum of two units per 12 months.

<u>Provider category</u>	<u>Basis of reimbursement</u>	<u>Upper limit</u>
Enhanced job search	Retrospectively limited prospective rates. See 79.1(15)	Effective 7/1/13: \$9.19 per 15-minute unit. Maximum of 104 units per 12 months.
Supports to maintain employment	Retrospectively limited prospective rates. See 79.1(15)	Effective 7/1/13: \$9.19 per 15-minute unit for all activities other than personal care and services in an enclave setting. \$5.20 per 15-minute unit for personal care. \$1.63 per 15-minute unit for services in an enclave setting. \$3,029.62 per month for total service. Maximum of 160 units per week.
20. Specialized medical equipment	Fee schedule. See 79.1(17)	Effective 7/1/13, \$6,366.64 per year.
21. Behavioral programming	Fee schedule	Effective 7/1/13, provider's rate in effect 6/30/13 plus 3%. If no 6/30/13 rate: \$11.34 per 15 minutes.
22. Family counseling and training	Fee schedule	Effective 7/1/13, provider's rate in effect 6/30/13 plus 3%, converted to a 15-minute rate. If no 6/30/13 rate: \$11.33 per 15-minute unit.
23. Prevocational services	Fee schedule	County contract rate or, in absence of a contract rate, effective 7/1/13: Lesser of provider's rate in effect 6/30/13 plus 3%, \$50.66 per day or \$13.87 per hour.
24. Interim medical monitoring and treatment:		
Home health agency (provided by home health aide)	Cost-based rate for home health aide services provided by a home health agency	Effective 7/1/13: Lesser of maximum Medicare rate in effect 6/30/13 plus 3%, converted to a 15-minute rate, or maximum Medicaid rate in effect 6/30/13 plus 3%, converted to a 15-minute rate.
Home health agency (provided by nurse)	Cost-based rate for nursing services provided by a home health agency	Effective 7/1/13: Lesser of maximum Medicare rate in effect 6/30/13 plus 3%, converted to a 15-minute rate, or maximum Medicaid rate in effect 6/30/13 plus 3%, converted to a 15-minute rate.
Child development home or center	Fee schedule	Effective 7/1/13, provider's rate in effect 6/30/13 plus 3%, converted to a 15-minute rate. If no 6/30/13 rate: \$3.45 per 15-minute unit.

<u>Provider category</u>	<u>Basis of reimbursement</u>	<u>Upper limit</u>
Supported community living provider	Retrospectively limited prospective rate. See 79.1(15)	Effective 7/1/13, provider's rate in effect 6/30/13 plus 3%, converted to a 15-minute rate. If no 6/30/13 rate: \$9.19 per 15-minute unit, not to exceed the maximum ICF/ID rate per day plus 3%.
25. Residential-based supported community living	Retrospectively limited prospective rates. See 79.1(15)	Effective 7/1/13: Not to exceed the maximum ICF/ID rate per day plus 3%.
26. Day habilitation	Fee schedule	Effective 7/1/13: County contract rate converted to a 15-minute or daily rate or, in the absence of a contract rate, provider's rate in effect 6/30/13 plus 3%, converted to a 15-minute or daily rate. If no 6/30/13 rate: \$3.47 per 15-minute unit or \$67.55 per day.
27. Environmental modifications and adaptive devices	Fee schedule. See 79.1(17)	Effective 7/1/13, \$6,366.64 per year.
28. Family and community support services	Retrospectively limited prospective rates. See 79.1(15)	Effective 7/1/13, provider's rate in effect 6/30/13 plus 3%, converted to a 15-minute rate. If no 6/30/13 rate: \$9.19 per 15-minute unit.
29. In-home family therapy	Fee schedule	Effective 7/1/13, provider's rate in effect 6/30/13 plus 3%, converted to a 15-minute rate. If no 6/30/13 rate: \$24.60 per 15-minute unit.
30. Financial management services	Fee schedule	Effective 7/1/13, provider's rate in effect 6/30/13 plus 3%. If no 6/30/13 rate: \$68.97 per enrolled member per month.
31. Independent support broker	Rate negotiated by member	Effective 7/1/13, provider's rate in effect 6/30/13 plus 3%. If no 6/30/13 rate: \$15.91 per hour.
32. Self-directed personal care	Rate negotiated by member	Determined by member's individual budget. When an individual who serves as a member's legal representative provides services to the member as allowed by 79.9(7) "b," the payment rate must be based on the skill level of the legal representative and may not exceed the median statewide reimbursement rate for the service unless the higher rate receives prior approval from the department.

<u>Provider category</u>	<u>Basis of reimbursement</u>	<u>Upper limit</u>
33. Self-directed community supports and employment	Rate negotiated by member	Determined by member's individual budget. When an individual who serves as a member's legal representative provides services to the member as allowed by 79.9(7) "b," the payment rate must be based on the skill level of the legal representative and may not exceed the median statewide reimbursement rate for the service unless the higher rate receives prior approval from the department.
34. Individual-directed goods and services	Rate negotiated by member	Determined by member's individual budget. When an individual who serves as a member's legal representative provides services to the member as allowed by 79.9(7) "b," the payment rate must be based on the skill level of the legal representative and may not exceed the median statewide reimbursement rate for the service unless the higher rate receives prior approval from the department.
35. Assisted living on-call service providers (elderly waiver only)	Fee agreed upon by member and provider.	\$25.75 per day.
Health home services provider	Fee schedule based on the member's qualifying health condition(s).	Monthly fee schedule amount.
Hearing aid dispensers	Fee schedule plus product acquisition cost	Fee schedule in effect 6/30/13 plus 1%.
Home- and community-based habilitation services:		
1. Case management	See 79.1(24) "d"	Retrospective cost-settled rate.
2. Home-based habilitation	See 79.1(24) "d"	Effective 7/1/13: \$11.68 per 15-minute unit, not to exceed \$6,083 per month, or \$200 per day.
3. Day habilitation	See 79.1(24) "d"	Effective 7/1/13: \$3.30 per 15-minute unit or \$64.29 per day.
4. Prevocational habilitation	See 79.1(24) "d"	Effective 7/1/13: \$13.47 per hour or \$48.22 per day.
5. Supported employment:		
Activities to obtain a job:		
Job development	See 79.1(24) "d"	\$909 per unit (job placement). Maximum of two units per 12 months.
Employer development	See 79.1(24) "d"	\$909 per unit (job placement). Maximum of two units per 12 months.

<u>Provider category</u>	<u>Basis of reimbursement</u>	<u>Upper limit</u>
Enhanced job search	See 79.1(24) “d”	Effective 7/1/13: Maximum of \$8.75 per 15-minute unit and 104 units per 12 months.
Supports to maintain employment	See 79.1(24) “d”	Effective 7/1/13: \$1.55 per 15-minute unit for services in an enclave setting; \$4.95 per 15-minute unit for personal care; and \$8.75 per 15-minute unit for all other services. Total not to exceed \$2,883.71 per month. Maximum of 160 units per week.
Home health agencies		
1. Skilled nursing, physical therapy, occupational therapy, speech therapy, home health aide, and medical social services; home health care for maternity patients and children	Fee schedule. See 79.1(26). For members living in a nursing facility, see 441—paragraph 81.6(11) “r.”	Effective 7/1/13: Medicare LUPA rates in effect on July 1, 2013, updated July 1 every two years.
2. Private-duty nursing and personal cares for members aged 20 or under	Retrospective cost-related. See 79.1(27)	Effective 7/1/13: Actual and allowable cost not to exceed a maximum of 133% of statewide average.
3. Administration of vaccines	Physician fee schedule	Physician fee schedule rate.
Hospices	Fee schedule as determined by Medicare	Medicare cap. (See 79.1(14) “d”)
Hospitals (Critical access)	Retrospectively adjusted prospective rates. See 79.1(1) “g” and 79.1(5)	The reasonable cost of covered services provided to medical assistance recipients or the upper limits for other hospitals, whichever is greater.
Hospitals (Inpatient)	Prospective reimbursement. See 79.1(5)	Reimbursement rate in effect 6/30/13 plus 1%.
Hospitals (Outpatient)	Prospective reimbursement or hospital outpatient fee schedule. See 79.1(16) “c”	Ambulatory payment classification rate or hospital outpatient fee schedule rate in effect 6/30/13 plus 1%.
Independent laboratories	Fee schedule. See 79.1(6)	Medicare fee schedule less 5%. See 79.1(6)
Indian health service 638 facilities	1. Base rate as determined by the United States Office of Management and Budget for outpatient visits for American Indian and Alaskan native members.	1. Office of Management and Budget rate published in the Federal Register for outpatient visit rate.
	2. Fee schedule for service provided for all other Medicaid members.	2. Fee schedule.
Infant and toddler program providers	Fee schedule	Fee schedule.
Intermediate care facilities for persons with an intellectual disability	Prospective reimbursement. See 441—82.5(249A)	Eightieth percentile of facility costs as calculated from annual cost reports.
Lead inspection agency	Fee schedule	Fee schedule in effect 6/30/13 plus 1%.

<u>Provider category</u>	<u>Basis of reimbursement</u>	<u>Upper limit</u>
Local education agency services providers	Fee schedule	Fee schedule.
Maternal health centers	Reasonable cost per procedure on a prospective basis as determined by the department based on financial and statistical data submitted annually by the provider group	Fee schedule in effect 6/30/13 plus 1%.
Nursing facilities: 1. Nursing facility care	Prospective reimbursement. See 441—subrule 81.10(1) and 441—81.6(249A). The percentage of the median used to calculate the direct care excess payment allowance ceiling under 441—81.6(16) “d”(1) “1” and (2) “1” is 95% of the patient-day-weighted median. The percentage of the difference used to calculate the direct care excess payment allowance is 0%. The percentage of the median used to calculate the direct care excess payment allowance limit is 10% of the patient-day-weighted median. The percentage of the median used to calculate the non-direct care excess payment allowance ceiling under 441—81.6(16) “d”(1) “2” and (2) “2” is 96% of the patient-day-weighted median. The percentage of the difference used to calculate the non-direct care excess payment allowance limit is 0%. The percentage of the median used to calculate the non-direct care excess payment allowance limit is 8% of the patient-day-weighted median.	See 441—subrules 81.6(4) and 81.6(14) and paragraph 81.6(16) “f.” The direct care rate component limit under 441—81.6(16) “f”(1) and (2) is 120% of the patient-day-weighted median. The non-direct care rate component limit under 441—81.6(16) “f”(1) and (2) is 110% of the patient-day-weighted median.

<u>Provider category</u>	<u>Basis of reimbursement</u>	<u>Upper limit</u>
2. Hospital-based, Medicare-certified nursing care	Prospective reimbursement. See 441—subrule 81.10(1) and 441—81.6(249A). The percentage of the median used to calculate the direct care excess payment allowance ceiling under 441—81.6(16) “d”(3) “1” is 95% of the patient-day-weighted median. The percentage of the difference used to calculate the direct care excess payment allowance is 0%. The percentage of the median used to calculate the direct care excess payment allowance limit is 10% of the patient-day-weighted median. The percentage of the median used to calculate the non-direct care excess payment allowance ceiling under 441—81.6(16) “d”(3) “2” is 96% of the patient-day-weighted median. The percentage of the difference used to calculate the non-direct care excess payment allowance limit is 0%. The percentage of the median used to calculate the non-direct care excess payment allowance limit is 8% of the patient-day-weighted median.	See subrules 441—81.6(4) and 81.6(14) and paragraph 81.6(16) “f.” The direct care rate component limit under 441—81.6(16) “f”(3) is 120% of the patient-day-weighted median. The non-direct care rate component limit under 441—81.6(16) “f”(3) is 110% of the patient-day-weighted median.
Occupational therapists	Fee schedule. For members residing in a nursing facility, see 441—paragraph 81.6(11) “r.”	Fee schedule in effect 6/30/13 plus 1%.
Opticians	Fee schedule. Fixed fee for lenses and frames; other optical materials at product acquisition cost	Fee schedule in effect 6/30/13 plus 1%.
Optometrists	Fee schedule. Fixed fee for lenses and frames; other optical materials at product acquisition cost	Fee schedule in effect 6/30/13 plus 1%.
Orthopedic shoe dealers	Fee schedule	Fee schedule in effect 6/30/13 plus 1%.
Pharmaceutical case management	Fee schedule. See 79.1(18)	Refer to 79.1(18).
Pharmacy administration of influenza vaccine to children	Physician fee schedule for immunization administration	Fee schedule in effect 6/30/13 plus 1%.
Physical therapists	Fee schedule. For members residing in a nursing facility, see 441—paragraph 81.6(11) “r.”	Fee schedule in effect 6/30/13 plus 1%.
Physicians (doctors of medicine or osteopathy)	Fee schedule. See 79.1(7) “a”	Fee schedule in effect 6/30/13 plus 1%.
Anesthesia services	Fee schedule	Fee schedule in effect 6/30/13 plus 1%.
Physician-administered drugs	Fee schedule	Fee schedule in effect 6/30/13 plus 1%.
Qualified primary care services	See 79.1(7) “c”	Rate provided by 79.1(7) “c”

<u>Provider category</u>	<u>Basis of reimbursement</u>	<u>Upper limit</u>
Podiatrists	Fee schedule	Fee schedule in effect 6/30/13 plus 1%.
Prescribed drugs	See 79.1(8)	Amount pursuant to 79.1(8).
Psychiatric medical institutions for children:		
1. Inpatient	Retrospective cost-related	Effective 8/1/11: Actual and allowable cost not to exceed a maximum for non-state-owned providers of 103% of patient-day-weighted average costs of non-state-owned providers located within Iowa.
2. Outpatient day treatment	Fee schedule	Fee schedule in effect 6/30/13 plus 1%.
Psychologists	Fee schedule	Fee schedule in effect 6/30/13 plus 1%.
Public health agencies	Fee schedule	Fee schedule rate in effect 6/30/13 plus 1%.
Rehabilitation agencies	Fee schedule. For members residing in a nursing facility, see 441—paragraph 81.6(11) “r.”	Medicaid fee schedule in effect 6/30/13 plus 1%; refer to 79.1(21).
Remedial services	Retrospective cost-related. See 79.1(23)	110% of average cost less 5%.
Rural health clinics	Retrospective cost-related. See 441—88.14(249A)	1. Prospective payment rate as required by the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA 2000) or an alternative methodology allowed thereunder, as specified in “2” below. 2. 100% of reasonable cost as determined by Medicare cost reimbursement principles. 3. In the case of services provided pursuant to a contract between an RHC and a managed care organization (MCO), reimbursement from the MCO shall be supplemented to achieve “1” or “2” above.
Screening centers	Fee schedule	Fee schedule in effect 6/30/13 plus 1%.
Speech-language pathologists	Fee schedule	Fee schedule in effect 6/30/13 plus 1%.
State-operated institutions	Retrospective cost-related	
Targeted case management providers	Fee for service with cost settlement. See 79.1(1) “d.”	Retrospective cost-settled rate.

79.1(3) Ambulatory surgical centers.

a. Payment is made for facility services on a fee schedule determined by the department and published on the department’s Web site. These fees are grouped into nine categories corresponding to the difficulty or complexity of the surgical procedure involved.

b. Services of the physician or the dentist are reimbursed on the basis of a fee schedule (see paragraph 79.1(1) “c”). This payment is made directly to the physician or dentist.

79.1(4) *Durable medical equipment, prosthetic devices, medical supply dealers.* Fees for durable medical appliances, prosthetic devices and medical supplies are developed from several pricing sources and are based on pricing appropriate to the date of service; prices are developed using prior calendar year price information. The average wholesale price from all available sources is averaged to determine the fee for each item. Payment for used equipment will be no more than 80 percent of the purchase allowance. For supplies, equipment, and servicing of standard wheelchairs, standard hospital beds, enteral nutrients, and enteral and parenteral supplies and equipment, the fee for payment shall be the lowest price for which the devices are widely and consistently available in a locality. Reimbursement over an established Medicaid fee schedule amount may be allowed pursuant to the criteria at 441—paragraph 78.10(5) “n.”

79.1(5) *Reimbursement for hospitals.*

a. Definitions.

“*Adolescent*” shall mean a Medicaid patient 17 years or younger.

“*Adult*” shall mean a Medicaid patient 18 years or older.

“*Average daily rate*” shall mean the hospital’s final payment rate multiplied by the DRG weight and divided by the statewide average length of stay for a DRG.

“*Base year cost report*” means the hospital’s cost report with fiscal year end on or after January 1, 2007, and before January 1, 2008, except as noted in 79.1(5) “x.” Cost reports shall be reviewed using Medicare’s cost reporting and cost reimbursement principles for those cost reporting periods.

“*Blended base amount*” shall mean the case-mix-adjusted, hospital-specific operating cost per discharge associated with treating Medicaid patients, plus the statewide average case-mix-adjusted operating cost per Medicaid discharge, divided by two. This base amount is the value to which payments for inflation and capital costs are added to form a final payment rate. The costs of hospitals receiving reimbursement as critical access hospitals during any of the period included in the base-year cost report shall not be used in determining the statewide average case-mix-adjusted operating cost per Medicaid discharge.

For purposes of calculating the disproportionate share rate only, a separate blended base amount shall be determined for any hospital that qualifies for a disproportionate share payment only as a children’s hospital based on a distinct area or areas serving children. This separate amount shall be determined using only the case-mix-adjusted operating cost per discharge associated with treating Medicaid patients in the distinct area or areas of the hospital where services are provided predominantly to children under 18 years of age.

“*Blended capital costs*” shall mean case-mix-adjusted hospital-specific capital costs, plus statewide average capital costs, divided by two. The costs of hospitals receiving reimbursement as critical access hospitals during any of the period of time included in the base-year cost report shall not be used in determining the statewide average capital costs.

For purposes of calculating the disproportionate share rate only, separate blended capital costs shall be determined for any hospital that qualifies for a disproportionate share payment only as a children’s hospital based on a distinct area or areas serving children, using only the capital costs related to the distinct area or areas of the hospital where services are provided predominantly to children under 18 years of age.

“*Capital costs*” shall mean an add-on to the blended base amount, which shall compensate for Medicaid’s portion of capital costs. Capital costs for buildings, fixtures and movable equipment are defined in the hospital’s base year cost report, are case-mix adjusted, are adjusted to reflect 80 percent of allowable costs, and are adjusted to be no greater than one standard deviation off the mean Medicaid blended capital rate.

For purposes of calculating the disproportionate share rate only, separate capital costs shall be determined for any hospital that qualifies for a disproportionate share payment only as a children’s hospital based on a distinct area or areas serving children, using only the base year cost report information related to the distinct area or areas of the hospital where services are provided predominantly to children under 18 years of age.

“*Case-mix adjusted*” shall mean the division of the hospital-specific base amount or other applicable components of the final payment rate by the hospital-specific case-mix index. For purposes of calculating

the disproportionate share rate only, a separate case-mix adjustment shall be determined for any hospital that qualifies for a disproportionate share payment only as a children's hospital based on a distinct area or areas serving children, using the base amount or other applicable component for the distinct area or areas of the hospital where services are provided predominantly to children under 18 years of age.

"Case-mix index" shall mean an arithmetical index measuring the relative average costliness of cases treated in a hospital compared to the statewide average. For purposes of calculating the disproportionate share rate only, a separate case-mix index shall be determined for any hospital that qualifies for a disproportionate share payment only as a children's hospital based on a distinct area or areas serving children, using the average costliness of cases treated in the distinct area or areas of the hospital where services are provided predominantly to children under 18 years of age.

"Children's hospitals" shall mean hospitals with inpatients predominantly under 18 years of age. For purposes of qualifying for disproportionate share payments from the graduate medical education and disproportionate share fund, a children's hospital is defined as a duly licensed hospital that:

1. Either provides services predominantly to children under 18 years of age or includes a distinct area or areas that provide services predominantly to children under 18 years of age, and

2. Is a voting member of the National Association of Children's Hospitals and Related Institutions for dates of service prior to October 1, 2014, or a member of the National Association of Children's Hospitals and Related Institutions for dates of service on or after October 1, 2014.

"Cost outlier" shall mean cases which have an extraordinarily high cost as established in 79.1(5) "f," so as to be eligible for additional payments above and beyond the initial DRG payment.

"Critical access hospital" or *"CAH"* means a hospital licensed as a critical access hospital by the department of inspections and appeals pursuant to rule 481—51.52(135B).

"Diagnosis-related group (DRG)" shall mean a group of similar diagnoses combined based on patient age, procedure coding, comorbidity, and complications.

"Direct medical education costs" shall mean costs directly associated with the medical education of interns and residents or other medical education programs, such as a nursing education program or allied health programs, conducted in an inpatient setting, that qualify for payment as medical education costs under the Medicare program. The amount of direct medical education costs is determined from the hospital base year cost reports and is inflated and case-mix adjusted in determining the direct medical education rate. Payment for direct medical education costs shall be made from the graduate medical education and disproportionate share fund and shall not be added to the reimbursement for claims.

For purposes of calculating the disproportionate share rate only, separate direct medical education costs shall be determined for any hospital that qualifies for a disproportionate share payment only as a children's hospital based on a distinct area or areas serving children, using only costs associated with the distinct area or areas in the hospital where services are provided predominantly to children under 18 years of age.

"Direct medical education rate" shall mean a rate calculated for a hospital reporting medical education costs on the Medicare cost report (CMS 2552). The rate is calculated using the following formula: Direct medical education costs are multiplied by inflation factors. The result is divided by the hospital's case-mix index, then is further divided by net discharges.

For purposes of calculating the disproportionate share rate only, a separate direct medical education rate shall be determined for any hospital that qualifies for a disproportionate share payment only as a children's hospital based on a distinct area or areas serving children, using the direct medical education costs, case-mix index, and net discharges of the distinct area or areas in the hospital where services are provided predominantly to children under 18 years of age.

"Disproportionate share payment" shall mean a payment that shall compensate for treatment of a disproportionate share of poor patients. On or after July 1, 1997, the disproportionate share payment shall be made directly from the graduate medical education and disproportionate share fund and shall not be added to the reimbursement for claims with discharge dates on or after July 1, 1997.

"Disproportionate share percentage" shall mean either (1) the product of 2½ percent multiplied by the number of standard deviations by which the hospital's own Medicaid inpatient utilization rate

exceeds the statewide mean Medicaid inpatient utilization rate for all hospitals, or (2) 2½ percent. (See 79.1(5)“y”(7).)

A separate disproportionate share percentage shall be determined for any hospital that qualifies for a disproportionate share payment only as a children’s hospital, using the Medicaid inpatient utilization rate for children under 18 years of age at the time of admission in all distinct areas of the hospital where services are provided predominantly to children under 18 years of age.

“*Disproportionate share rate*” shall mean the sum of the blended base amount, blended capital costs, direct medical education rate, and indirect medical education rate multiplied by the disproportionate share percentage.

“*DRG weight*” shall mean a number that reflects relative resource consumption as measured by the relative charges by hospitals for cases associated with each DRG. That is, the Iowa-specific DRG weight reflects the relative charge for treating cases classified in a particular DRG compared to the average charge for treating all Medicaid cases in all DRGs in Iowa hospitals.

“*Final payment rate*” shall mean the aggregate sum of the two components (the blended base amount and capital costs) that, when added together, form the final dollar value used to calculate each provider’s reimbursement amount when multiplied by the DRG weight. These dollar values are displayed on the rate table listing.

“*Full DRG transfer*” shall mean that a case, coded as a transfer to another hospital, shall be considered to be a normal claim for recalibration or rebasing purposes if payment is equal to or greater than the full DRG payment.

“*GME/DSH fund apportionment claim set*” means the hospital’s applicable Medicaid claims paid from July 1, 2008, through June 30, 2009. The claim set is updated in July of every third year.

“*GME/DSH fund implementation year*” means 2009.

“*Graduate medical education and disproportionate share fund*” or “*GME/DSH fund*” means a reimbursement fund developed as an adjunct reimbursement methodology to directly reimburse qualifying hospitals for the direct and indirect costs associated with the operation of graduate medical education programs and the costs associated with the treatment of a disproportionate share of poor, indigent, nonreimbursed or nominally reimbursed patients for inpatient services.

“*Indirect medical education rate*” shall mean a rate calculated as follows: The statewide average case-mix adjusted operating cost per Medicaid discharge, divided by two, is added to the statewide average capital costs, divided by two. The resulting sum is then multiplied by the ratio of the number of full-time equivalent interns and residents serving in a Medicare-approved hospital teaching program divided by the number of beds included in hospital departments served by the interns’ and residents’ program, and is further multiplied by 1.159.

For purposes of calculating the disproportionate share rate only, a separate indirect medical education rate shall be determined for any hospital that qualifies for a disproportionate share payment only as a children’s hospital based on a distinct area or areas serving children, using the number of full-time equivalent interns and residents and the number of beds in the distinct area or areas in the hospital where services are provided predominantly to children under 18 years of age.

“*Inlier*” shall mean those cases where the length of stay or cost of treatment falls within the actual calculated length of stay criteria, or the cost of treating a patient is within the cost boundaries of a DRG payment.

“*Long stay outlier*” shall mean cases which have an associated length of stay that is greater than the calculated length of stay parameters as defined within the length of stay calculations for that DRG. Payment is as established in 79.1(5)“f.”

“*Low-income utilization rate*” shall mean the ratio of gross billings for all Medicaid, bad debt, and charity care patients, including billings for Medicaid enrollees of managed care organizations and primary care case management organizations, to total billings for all patients. Gross billings do not include cash subsidies received by the hospital for inpatient hospital services except as provided from state or local governments.

A separate low-income utilization rate shall be determined for any hospital qualifying or seeking to qualify for a disproportionate share payment as a children’s hospital, using only billings for patients

under 18 years of age at the time of admission in the distinct area or areas in the hospital where services are provided predominantly to children under 18 years of age.

“Medicaid claim set” means the hospital’s applicable Medicaid claims for the period of January 1, 2006, through December 31, 2007, and paid through March 31, 2008.

“Medicaid inpatient utilization rate” shall mean the number of total Medicaid days, including days for Medicaid enrollees of managed care organizations and primary care case management organizations, both in-state and out-of-state, and Iowa state indigent patient days divided by the number of total inpatient days for both in-state and out-of-state recipients. Children’s hospitals, including hospitals qualifying for disproportionate share as a children’s hospital, receive twice the percentage of inpatient hospital days attributable to Medicaid patients.

A separate Medicaid inpatient utilization rate shall be determined for any hospital qualifying or seeking to qualify for a disproportionate share payment as a children’s hospital, using only Medicaid days, Iowa state indigent patient days, and total inpatient days attributable to patients under 18 years of age at the time of admission in all distinct areas of the hospital where services are provided predominantly to children under 18 years of age.

“Neonatal intensive care unit” shall mean a designated level II or level III neonatal unit.

“Net discharges” shall mean total discharges minus transfers and short stay outliers.

“Quality improvement organization” or *“QIO”* shall mean the organization that performs medical peer review of Medicaid claims, including review of validity of hospital diagnosis and procedure coding information; completeness, adequacy and quality of care; appropriateness of admission, discharge and transfer; and appropriateness of prospective payment outlier cases. These activities undertaken by the QIO may be included in a contractual relationship with the Iowa Medicaid enterprise.

“Rate table listing” shall mean a schedule of rate payments for each provider. The rate table listing is defined as the output that shows the final payment rate by hospital before being multiplied by the appropriate DRG weight.

“Rebasing” shall mean the redetermination of the blended base amount or other applicable components of the final payment rate from more recent Medicaid cost report data.

“Rebasing implementation year” means 2008 and every three years thereafter.

“Recalibration” shall mean the adjustment of all DRG weights to reflect changes in relative resource consumption.

“Short stay day outlier” shall mean cases which have an associated length of stay that is less than the calculated length of stay parameters as defined within the length of stay calculations. Payment rates are established in 79.1(5)*“f.”*

b. Determination of final payment rate amount. The hospital DRG final payment amount reflects the sum of inflation adjustments to the blended base amount plus an add-on for capital costs. This blended base amount plus the add-on is multiplied by the set of Iowa-specific DRG weights to establish a rate schedule for each hospital. Federal DRG definitions are adopted except as provided below:

(1) Substance abuse units certified pursuant to 79.1(5)*“r.”* Three sets of DRG weights are developed for DRGs concerning rehabilitation of substance abuse patients. The first set of weights is developed from charges associated with treating adults in certified substance abuse units. The second set of weights reflects charges associated with treating adolescents in mixed-age certified substance abuse units. The third set of weights reflects charges associated with treating adolescents in designated adolescent-only certified substance abuse units.

Hospitals with these units are reimbursed using the weight that reflects the age of each patient. Out-of-state hospitals may not receive reimbursement for the rehabilitation portion of substance abuse treatment.

(2) Neonatal intensive care units certified pursuant to 79.1(5)*“r.”* Three sets of weights are developed for DRGs concerning treatment of neonates. One set of weights is developed from charges associated with treating neonates in a designated level III neonatal intensive care unit for some portion of their hospitalization. The second set of weights is developed from charges associated with treating neonates in a designated level II neonatal intensive care unit for some portion of their hospitalization.

The third set of weights reflects charges associated with neonates not treated in a designated level II or level III setting. Hospitals are reimbursed using the weight that reflects the setting for neonate treatment.

(3) Psychiatric units. Rescinded IAB 8/29/07, effective 8/10/07.

c. *Calculation of Iowa-specific weights and case-mix index.* From the Medicaid claim set, the recalibration for rates effective October 1, 2008, will use all normal inlier claims, discard short stay outliers, discard transfers where the final payment is less than the full DRG payment, include transfers where the full payment is greater than or equal to the full DRG payment, and use only the estimated charge for the inlier portion of long stay outliers and cost outliers for weighting calculations. These are referred to as trimmed claims.

(1) Iowa-specific weights are calculated with Medicaid charge data from the Medicaid claim set using trimmed claims. Medicaid charge data for hospitals receiving reimbursement as critical access hospitals during any of the period included in the base-year cost report shall not be used in calculating Iowa-specific weights. One weight is determined for each DRG with noted exceptions. Weights are determined through the following calculations:

1. Determine the statewide geometric mean charge for all cases classified in each DRG.
2. Compute the statewide aggregate geometric mean charge for each DRG by multiplying the statewide geometric mean charge for each DRG by the total number of cases classified in that DRG.
3. Sum the statewide aggregate geometric mean charges for all DRGs and divide by the total number of cases for all DRGs to determine the weighted average charge for all DRGs.
4. Divide the statewide geometric mean charge for each DRG by the weighted average charge for all DRGs to derive the Iowa-specific weight for each DRG.
5. Normalize the weights so that the average case has a weight of one.

(2) The hospital-specific case-mix index is computed by taking each hospital's trimmed claims that match the hospital's base year cost reporting period, summing the assigned DRG weights associated with those claims and dividing by the total number of Medicaid claims associated with that specific hospital for that period. Case-mix indices are not computed for hospitals receiving reimbursement as critical access hospitals.

(3) For purposes of calculating the disproportionate share rate only, a separate hospital-specific case-mix index shall be computed for any hospital that qualifies for a disproportionate share payment only as a children's hospital. The computation shall use only claims and associated DRG weights for services provided to patients under 18 years of age at the time of admission in all distinct areas of the hospital where services are provided predominantly to children under 18 years of age.

d. *Calculation of blended base amount.* The DRG blended base amount reflects a 50/50 blend of statewide and hospital-specific base amounts.

(1) Calculation of statewide average case-mix-adjusted cost per discharge. The statewide average cost per discharge is calculated by subtracting from the statewide total Iowa Medicaid inpatient expenditures:

1. The total calculated dollar expenditures based on hospitals' base-year cost reports for capital costs and medical education costs, and
2. The actual payments made for additional transfers, outliers, physical rehabilitation services, psychiatric services rendered on or after October 1, 2006, and indirect medical education.

Cost report data for hospitals receiving reimbursement as critical access hospitals during any of the period of time included in the base-year cost report is not used in calculating the statewide average cost per discharge. The remaining amount (which has been case-mix adjusted and adjusted to reflect inflation if applicable) is divided by the statewide total number of Iowa Medicaid discharges reported in the Medicaid management information system (MMIS) less an actual number of nonfull DRG transfers and short stay outliers.

(2) Calculation of hospital-specific case-mix-adjusted average cost per discharge. The hospital-specific case-mix-adjusted average cost per discharge is calculated by subtracting from the lesser of total Iowa Medicaid costs or covered reasonable charges, as determined by the hospital's base-year cost report or MMIS claims system, the actual dollar expenditures for capital costs, direct medical education costs, and the payments made for nonfull DRG transfers, outliers, physical

rehabilitation services, and psychiatric services rendered on or after October 1, 2006, if applicable. The remaining amount is case-mix adjusted, multiplied by inflation factors, and divided by the total number of Iowa Medicaid discharges from the MMIS claims system for that hospital during the applicable base year, less the nonfull DRG transfers and short stay outliers.

For purposes of calculating the disproportionate share rate only, a separate hospital-specific case-mix-adjusted average cost per discharge shall be calculated for any hospital that qualifies for a disproportionate share payment only as a children's hospital based on a distinct area or areas serving children, using the costs, charges, expenditures, payments, discharges, transfers, and outliers attributable to the distinct area or areas in the hospital where services are provided predominantly to children under 18 years of age.

(3) Calculation of the blended statewide and hospital-specific base amount. The hospital-specific case-mix adjusted average cost per discharge is added to the case-mix adjusted statewide average cost per discharge and divided by two to arrive at a 50/50 blended base amount.

e. Add-ons to the base amount.

(1) One payment for capital costs is added on to the blended base amount.

Capital costs are included in the rate table listing and added to the blended base amount before the final payment rate schedule is set. This add-on reflects a 50/50 blend of the statewide average case-mix-adjusted capital cost per discharge and the case-mix-adjusted hospital-specific base-year capital cost per discharge attributed to Iowa Medicaid patients.

Allowable capital costs are determined by multiplying the capital amount from the base-year cost report by 80 percent. Cost report data for hospitals receiving reimbursement as critical access hospitals during any of the period of time included in the base-year cost report is not used in calculating the statewide average case-mix-adjusted capital cost per discharge.

The 50/50 blend is calculated by adding the case-mix-adjusted hospital-specific per discharge capital cost to the statewide average case-mix-adjusted per discharge capital costs and dividing by two. Hospitals whose blended capital add-on exceeds one standard deviation off the mean Medicaid blended capital rate will be subject to a reduction in their capital add-on to equal the first standard deviation.

For purposes of calculating the disproportionate share rate only, a separate add-on to the base amount for capital costs shall be calculated for any hospital that qualifies for a disproportionate share payment only as a children's hospital based on a distinct area or areas serving children, using the case-mix-adjusted hospital-specific base-year capital cost per discharge attributed to Iowa Medicaid patients in the distinct area or areas in the hospital where services are provided predominantly to children under 18 years of age.

(2) Rescinded IAB 7/6/05, effective 7/1/05.

f. Outlier payment policy. Additional payment is made for approved cases meeting or exceeding Medicaid criteria for day and cost outliers for each DRG. Effective for claims with dates of services ending July 1, 1993, and after, 100 percent of outlier costs will be paid to facilities at the time of claim reimbursement. The QIO shall perform retrospective outlier reviews in accordance with the terms in the contract between the department and the QIO. The QIO contract is available for review at the Iowa Medicaid Enterprise, 100 Army Post Road, Des Moines, Iowa.

(1) Long stay outliers. Long stay outliers are incurred when a patient's stay exceeds the upper day limit threshold. This threshold is defined as the lesser of the arithmetically calculated average length of stay plus 23 days of care or two standard deviations above the average statewide length of stay for a given DRG, calculated geometrically. Reimbursement for long stay outliers is calculated at 60 percent of the average daily rate for the given DRG for each approved day of stay beyond the upper day limit. Payment for long stay outliers shall be paid at 100 percent of the calculated amount and made at the time the claim is originally paid.

(2) Short stay outliers. Short stay outliers are incurred when a patient's length of stay is greater than two standard deviations from the geometric mean below the average statewide length of stay for a given DRG, rounded to the next highest whole number of days. Payment for short stay outliers will be 200 percent of the average daily rate for each day the patient qualifies up to the full DRG payment. Short stay outlier claims will be subject to QIO review and payment denied for inappropriate admissions.

(3) Cost outliers. Cases qualify as cost outliers when costs of service in a given case, not including any add-on amounts for direct or indirect medical education or disproportionate share costs exceed the cost threshold. This cost threshold is determined to be the greater of two times the statewide average DRG payment for that case or the hospital's individual DRG payment for that case plus \$16,000. Costs are calculated using hospital-specific cost-to-charge ratios determined in the base-year cost reports. Additional payment for cost outliers is 80 percent of the excess between the hospital's cost for the discharge and the cost threshold established to define cost outliers. Payment of cost outlier amounts shall be paid at 100 percent of the calculated amount and made at the time the claim is paid.

Those hospitals that are notified of any outlier review initiated by the QIO must submit all requested supporting data to the QIO within 60 days of the receipt of outlier review notification, or outlier payment will be forfeited and recouped. In addition, any hospital may request a review for outlier payment by submitting documentation to the QIO within 365 days of receipt of the outlier payment. If requests are not filed within 365 days, the provider loses the right to appeal or contest that payment.

(4) Day and cost outliers. Cases qualifying as both day and cost outliers are given additional payment as cost outliers only.

g. Billing for patient transfers and readmissions.

(1) Transfers between hospitals. When a Medicaid patient is transferred the initial hospital or unit is paid 100 percent of the average daily rate of the transferring hospital's payment for each day the patient remained in that hospital or unit, up to 100 percent of the entire DRG payment. The hospital or unit that received the transferred patient receives the entire DRG payment.

(2) Substance abuse units. When a patient is discharged to or from an acute care hospital and is admitted to or from a substance abuse unit certified pursuant to paragraph 79.1(5) "r," both the discharging and admitting hospitals will receive 100 percent of the DRG payment.

(3) Physical rehabilitation hospitals or units. When a patient requiring physical rehabilitation is discharged from an acute care hospital and admitted to a rehabilitation hospital or unit certified pursuant to 79.1(5) "r," and the admission is medically appropriate, then payment for time spent in the unit is through a per diem. The discharging hospital will receive 100 percent of the DRG payment. When a patient is discharged from a certified physical rehabilitation hospital or unit and admitted to an acute care hospital, the acute care hospital will receive 100 percent of the DRG payment.

When a patient requiring physical rehabilitation is discharged from a facility other than an acute care hospital and admitted to a rehabilitation hospital or unit certified pursuant to 79.1(5) "r," and the admission is medically appropriate, then payment for time spent in the unit is based on a per diem. The other facility will receive payment in accordance with rules governing that facility. When a patient is discharged from a certified physical rehabilitation hospital or unit and admitted to a facility other than an acute care hospital, the other facility will receive payment in accordance with rules governing that facility.

(4) Psychiatric units. When a patient is discharged to or from an acute care hospital before October 1, 2006, and is admitted to or from a psychiatric unit certified pursuant to paragraph 79.1(5) "r," both the discharging and admitting hospitals will receive 100 percent of the DRG payment.

Effective October 1, 2006, when a patient requiring psychiatric care is discharged from an acute care hospital and admitted to a psychiatric unit certified pursuant to paragraph 79.1(5) "r," and the admission is medically appropriate, then payment for time spent in the unit is through a per diem. The discharging hospital will receive 100 percent of the DRG payment. When a patient is discharged from a certified psychiatric unit and is admitted to an acute care hospital, the acute care hospital will receive 100 percent of the DRG payment.

When a patient requiring psychiatric care is discharged from a facility other than an acute care hospital on or after October 1, 2006, and is admitted to a psychiatric unit certified pursuant to paragraph 79.1(5) "r," and the admission is medically appropriate, then payment for time spent in the unit is based on a per diem. The other facility will receive payment in accordance with rules governing that facility. When a patient is discharged from a certified psychiatric unit on or after October 1, 2006, and is admitted to a facility other than an acute care hospital, the other facility will receive payment in accordance with rules governing that facility.

(5) Inpatient readmissions within seven days for same condition. When an inpatient is discharged or transferred from an acute care hospital and is readmitted as an inpatient to the same hospital within seven days for the same condition, any claim for the subsequent inpatient stay shall be combined with the claim for the original inpatient stay and payment shall be under a single DRG for both stays.

h. Covered DRGs. Medicaid DRGs cover services provided in acute care general hospitals, with the exception of services provided in physical rehabilitation hospitals and units certified pursuant to paragraph 79.1(5)“r,” and services provided on or after October 1, 2006, in psychiatric units certified pursuant to paragraph 79.1(5)“r,” which are paid per diem, as specified in paragraph 79.1(5)“i.”

i. Payment for certified physical rehabilitation hospitals and units and psychiatric units. Payment for services provided by a physical rehabilitation hospital or unit certified pursuant to paragraph 79.1(5)“r” and for services provided on or after October 1, 2006, in a psychiatric unit certified pursuant to paragraph 79.1(5)“r” is prospective. The payment is based on a per diem rate calculated for each hospital by establishing a base-year per diem rate to which an annual index is applied.

(1) Per diem calculation. The base rate shall be the medical assistance per diem rate as determined by the individual hospital’s base-year cost report pursuant to paragraph 79.1(5)“a.” No recognition will be given to the professional component of the hospital-based physicians except as noted under paragraph 79.1(5)“j.”

(2) Rescinded IAB 5/12/93, effective 7/1/93.

(3) Per diem reimbursement. Hospitals shall be reimbursed the lower of actual charges or the medical assistance cost per diem rate. The determination of the applicable rate shall be based on the hospital fiscal year aggregate of actual charges and medical assistance cost per diem rate. If an overpayment exists, the hospital will refund or have the overpayment deducted from subsequent billings.

(4) Per diem recalculation. Hospital prospective reimbursement rates shall be established as of October 1, 1987, for the remainder of the applicable hospital fiscal year. Beginning July 1, 1988, all updated rates shall be established based on the state’s fiscal year.

(5) Per diem billing. The current method for submitting billing and cost reports shall be maintained. All cost reports will be subject to desk review audit and, if necessary, a field audit.

j. Services covered by DRG payments. Medicaid adopts the Medicare definition of inpatient hospital services covered by the DRG prospective payment system except as indicated herein. As a result, combined billing for physician services is eliminated unless the hospital has approval from Medicare to combine bill the physician and hospital services. Teaching hospitals having Medicare’s approval to receive reasonable cost reimbursement for physician services under 42 CFR 415.58 as amended to November 25, 1991, are eligible for combined billing status if they have the Medicare approval notice on file with Iowa Medicaid as verification. Reasonable cost settlement will be made during the year-end settlement process. Services provided by certified nurse anesthetists (CRNAs) employed by a physician are covered by the physician reimbursement. Payment for the services of CRNAs employed by the hospital are included in the hospital’s reimbursement.

The cost for hospital-based ambulance transportation that results in an inpatient admission and hospital-based ambulance services performed while the recipient is an inpatient, in addition to all other inpatient services, is covered by the DRG payment. If, during the inpatient stay at the originating hospital, it becomes necessary to transport but not transfer the patient to another hospital or provider for treatment, with the patient remaining an inpatient at the originating hospital after that treatment, the originating hospital shall bear all costs incurred by that patient for the medical treatment or the ambulance transportation between the originating hospital and the other provider. The services furnished to the patient by the other provider shall be the responsibility of the originating hospital. Reimbursement to the originating hospital for all services is under the DRG payment. (See 441—subrule 78.11(4).)

k. Inflation factors, rebasing, and recalibration.

(1) Inflation factors shall be set annually at levels that ensure payments that are consistent with efficiency, economy, and quality of care and that are sufficient to enlist enough providers so that care and services are available at least to the extent that such care and services are available to the general population in the geographic area.

(2) Base amounts shall be rebased and weights recalibrated in 2005 and every three years thereafter. Cost reports used in rebasing shall be the hospital fiscal year-end Form CMS 2552, Hospital and Healthcare Complex Cost Report, as submitted to Medicare in accordance with Medicare cost report submission time lines for the hospital fiscal year ending during the calendar year preceding the rebasing implementation year. If a hospital does not provide this cost report to the Iowa Medicaid enterprise provider cost audits and rate setting unit by May 31 of a rebasing implementation year, the most recent submitted cost report will be used with the addition of a hospital market basket index inflation factor.

(3) The graduate medical education and disproportionate share fund shall be updated as provided in subparagraphs 79.1(5)“y”(3), (6), and (9).

(4) Hospitals receiving reimbursement as critical access hospitals shall not receive inflation of base payment amounts and shall not have base amounts rebased or weights recalibrated pursuant to this paragraph.

l. Eligibility and payment. When a client is eligible for Medicaid for less than or equal to the average length of stay for that DRG, then payment equals 100 percent of the hospital's average daily rate times the number of eligible hospital stay days up to the amount of the DRG payment. When a Medicaid client is eligible for greater than the average length of stay but less than the entire stay, then payment is treated as if the client were eligible for the entire length of stay.

Long stay outlier days are determined as the number of Medicaid eligible days beyond the outlier limits. The date of patient admission is the first date of service. Long stay outlier costs are accrued only during eligible days.

m. Payment to out-of-state hospitals. Payment made to out-of-state hospitals providing care to beneficiaries of Iowa's Medicaid program is equal to either the Iowa statewide average blended base amount plus the statewide average capital cost add-on, multiplied by the DRG weight, or blended base and capital rates calculated by using 80 percent of the hospital's submitted capital costs. Hospitals that submit a cost report no later than May 31 in the most recent rebasing year will receive a case-mix-adjusted blended base rate using hospital-specific, Iowa-only Medicaid data and the Iowa statewide average cost per discharge amount.

(1) Capital costs will be reimbursed at either the statewide average rate in place at the time of discharge, or the blended capital rate computed by using submitted cost report data.

(2) Hospitals that qualify for disproportionate share payment based on the definition established by their state's Medicaid agency for the calculation of the Medicaid inpatient utilization rate will be eligible to receive disproportionate share payments according to paragraph 79.1(5)“y,” for dates of service prior to October 1, 2014. Out-of-state hospitals do not qualify for disproportionate share payments for dates of service on or after October 1, 2014.

(3) Out-of-state hospitals do not qualify for direct medical education or indirect medical education payments pursuant to paragraph 79.1(5)“y.”

n. Preadmission, preauthorization, or inappropriate services. Medicaid adopts most Medicare QIO regulations to control increased admissions or reduced services. Exceptions to the Medicare review practice are that the QIO reviews Medicaid short stay outliers and all Medicaid patients readmitted within 31 days. Payment can be denied if either admissions or discharges are performed without medical justification as determined by the QIO. Inpatient or outpatient services which require preadmission or preprocedure approval by the QIO are updated yearly by the department and are listed in the provider manual. Preauthorization for any of these services is transmitted directly from the QIO to the Iowa Medicaid enterprise and no additional information needs to be submitted as part of the claim filing for inpatient or outpatient services. To safeguard against these and other inappropriate practices, the department through the QIO will monitor admission practices and quality of care. If an abuse of the prospective payment system is identified, payments for abusive practices may be reduced or denied. In reducing or denying payment, Medicaid adopts the Medicare QIO regulations.

o. Hospital billing. Hospitals shall normally submit claims for DRG reimbursement to the Iowa Medicaid enterprise after a patient's discharge.

(1) Payment for outlier days or costs is determined when the claim is paid by the Iowa Medicaid enterprise, as described in paragraph “f.”

(2) When a Medicaid patient requires acute care in the same facility for a period of no less than 120 days, a request for partial payment may be made. Written requests for this interim DRG payment shall be addressed to the Iowa Medicaid Enterprise, Attention: Provider Services Unit, P.O. Box 36450, Des Moines, Iowa 50315. A request for interim payment shall include:

1. The patient's name, state identification number, and date of admission;
2. A brief summary of the case;
3. A current listing of charges; and
4. A physician's attestation that the recipient has been an inpatient for 120 days and is expected to remain in the hospital for a period of no less than 60 additional days.

A departmental representative will then contact the facility to assist the facility in filing the interim claim.

p. Determination of inpatient admission. A person is considered to be an inpatient when a formal inpatient admission occurs, when a physician intends to admit a person as an inpatient, or when a physician determines that a person being observed as an outpatient in an observation or holding bed should be admitted to the hospital as an inpatient.

(1) In cases involving outpatient observation status, the determinant of patient status is not the length of time the patient was being observed, but rather that the observation period was medically necessary for the physician to determine whether a patient should be released from the hospital or admitted to the hospital as an inpatient.

(2) Outpatient observation lasting greater than a 24-hour period will be subject to review by the Iowa Medicaid Enterprise (IME) Medical Services Unit to determine the medical necessity of each case. For those outpatient observation cases where medical necessity is not established by the IME, reimbursement shall be denied for the services found to be unnecessary for the provision of that care, such as the use of the observation room.

q. Inpatient admission after outpatient services. A patient may be admitted to the hospital as an inpatient after receiving outpatient services. If the patient is admitted as an inpatient within three days of the day outpatient services were rendered, all outpatient services related to the principal diagnosis are considered inpatient services for billing purposes. The day of formal admission as an inpatient is considered as the first day of hospital inpatient services.

r. Certification for reimbursement as a special unit or physical rehabilitation hospital. Certification for Medicaid reimbursement as a substance abuse unit under subparagraph 79.1(5)“b”(1), a neonatal intensive care unit under subparagraph 79.1(5)“b”(2), a psychiatric unit under paragraph 79.1(5)“i,” or a physical rehabilitation hospital or unit under paragraph 79.1(5)“i” shall be awarded as provided in this paragraph.

(1) Certification procedure. All hospital special units and physical rehabilitation hospitals must be certified by the Iowa Medicaid enterprise to qualify for Medicaid reimbursement as a special unit or physical rehabilitation hospital. Hospitals shall submit requests for certification to Iowa Medicaid Enterprise, Attention: Provider Services Unit, P.O. Box 36450, Des Moines, Iowa 50315, with documentation that the certification requirements are met. The provider services unit will notify the facility of any additional documentation needed after review of the submitted documentation.

Upon certification, reimbursement as a special unit or physical rehabilitation hospital shall be retroactive to the first day of the month during which the Iowa Medicaid enterprise received the request for certification. No additional retroactive payment adjustment shall be made when a hospital fails to make a timely request for certification.

(2) Certification criteria for substance abuse units. An in-state substance abuse unit may be certified for Medicaid reimbursement under 79.1(5)“b”(1) if the unit's program is licensed by the Iowa department of public health as a substance abuse treatment program in accordance with Iowa Code chapter 125 and 643—Chapter 3. In addition to documentation of the license, an in-state hospital must submit documentation of the specific substance abuse programs available at the facility with a description of their staffing, treatment standards, and population served.

An out-of-state substance abuse unit may be certified for Medicaid reimbursement under 79.1(5)“b”(1) if it is excluded from the Medicare prospective payment system as a psychiatric unit

pursuant to 42 Code of Federal Regulations, Sections 412.25 and 412.27, as amended to September 1, 1994. An out-of-state hospital requesting reimbursement as a substance abuse unit must initially submit a copy of its current Medicare prospective payment system exemption notice, unless the facility had certification for reimbursement as a substance abuse unit before July 1, 1993. All out-of-state hospitals certified for reimbursement for substance abuse units must submit copies of new Medicare prospective payment system exemption notices as they are issued, at least annually.

(3) Certification criteria for neonatal intensive care units. A neonatal intensive care unit may be certified for Medicaid reimbursement under 79.1(5) “b”(2) if it is certified as a level II or level III neonatal unit and the hospital where it is located is accredited by the Joint Commission on Accreditation of Healthcare Organizations or the American Osteopathic Association. The Iowa Medicaid enterprise shall verify the unit’s certification as a level II or level III neonatal unit in accordance with recommendations set forth by the American Academy of Pediatrics for newborn care. Neonatal units in Iowa shall be certified by the Iowa department of public health pursuant to 641—Chapter 150. Out-of-state units shall submit proof of level II or level III certification.

(4) Certification criteria for psychiatric units. A psychiatric unit may be certified for Medicaid reimbursement under paragraph 79.1(5) “i” if it is excluded from the Medicare prospective payment system as a psychiatric unit pursuant to 42 Code of Federal Regulations, Sections 412.25 and 412.27 as amended to August 1, 2002.

(5) Certification criteria for physical rehabilitation hospitals and units. A physical rehabilitation hospital or unit may be certified for Medicaid reimbursement under 79.1(5) “i” if it receives or qualifies to receive Medicare reimbursement as a rehabilitative hospital or unit pursuant to 42 Code of Federal Regulations, Sections 412.600 through 412.632 (Subpart P), as amended to January 1, 2002, and the hospital is accredited by the Joint Commission on Accreditation of Healthcare Organizations or the American Osteopathic Association.

s. *Health care access assessment inflation factor.* Effective with the implementation of the health care access assessment paid pursuant to 441—Chapter 36, Division III, a health care access assessment inflation factor shall be applied to the Medicaid DRG blended base amount as otherwise calculated pursuant to this subrule for all “participating hospitals” as defined in 441—subrule 36.10(1).

(1) Calculation of inflation factor. The health care access assessment inflation factor for participating hospitals shall be calculated by dividing the amount allowed under the Medicare inpatient upper payment limit for the fiscal year beginning July 1, 2010, by the sum of the projected expenditures for participating hospitals for the fiscal year beginning July 1, 2010, as determined by the fiscal management division of the department, and the amount allowed under the Medicare inpatient upper payment limit.

(2) Implementation date. The health care access assessment inflation factor shall not be applied until federal financial participation to match money collected from the health care access assessment pursuant to 441—Chapter 36, Division III, has been approved by the federal Centers for Medicare and Medicaid Services.

(3) End date. Application of the health care access assessment inflation factor shall terminate if the health care access assessment is terminated pursuant to rule 441—36.12(83GA,SF2388). If federal match money is unavailable for a retroactive period or the authority to collect the assessment is rescinded for a retroactive period, the department shall:

1. Recalculate Medicaid rates in effect during that period without the application of the health care access assessment inflation factor;
2. Recompute Medicaid payments due based on the recalculated Medicaid rates;
3. Recoup any previous overpayments; and
4. Determine for each hospital the amount of health care access assessment collected during that period and refund that amount to the facility.

t. *Limitations and application of limitations on payment.* Diagnosis-related group payments are subject to the upper payment limits as stated in 42 CFR 447.271 and 42 CFR 447.272 as amended to September 5, 2001.

(1) The department may not pay a provider more for inpatient hospital services under Medicaid than the provider's customary charges to the general public for the services. This limit is applied in the aggregate during the cost settlement process at the end of the hospital's fiscal year.

(2) Aggregate payments to hospitals and state-operated hospitals may not exceed the amount that can reasonably be estimated would have been paid for those services under Medicare payment principles. This limit is applied to aggregate Medicaid payments at the end of the state's fiscal year.

u. State-owned teaching hospital disproportionate share payment. In addition to payments from the graduate medical education and disproportionate share fund made pursuant to paragraph 79.1(5) "y," payment shall be made to Iowa hospitals qualifying for the Iowa state-owned teaching hospital disproportionate share fund. Interim monthly payments based on estimated allowable costs will be paid to qualifying hospitals under this paragraph.

(1) Qualifying criteria. A hospital qualifies for Iowa state-owned teaching hospital disproportionate share payments if it qualifies for disproportionate share payments pursuant to paragraph 79.1(5) "y" and is an Iowa state-owned hospital with more than 500 beds and eight or more distinct residency specialty or subspecialty programs recognized by the American College of Graduate Medical Education.

(2) Allocation to fund. The total amount of funding that is allocated on July 1 of each year to the Iowa state-owned teaching hospital disproportionate share fund is \$26,633,430.

(3) Amount of payment. The total amount of disproportionate share payments from the graduate medical education and disproportionate share fund and from the Iowa state-owned teaching hospital disproportionate share fund shall not exceed the amount of the state's allotment under Public Law 102-234. In addition, the total amount of all disproportionate share payments shall not exceed the hospital-specific disproportionate share limits under Public Law 103-666.

(4) Final disproportionate share adjustment. The department's total year-end disproportionate share obligations to a qualifying hospital will be calculated following completion of the desk review or audit of CMS 2552-96, Hospital and Healthcare Complex Cost Report.

v. Non-state-owned teaching hospital disproportionate share payment. In addition to payments from the graduate medical education and disproportionate share fund made pursuant to paragraph 79.1(5) "y," payment shall be made to Iowa hospitals qualifying for Iowa non-state-government-owned acute care teaching hospital disproportionate share payments. Interim monthly payments based on estimated allowable costs will be paid to qualifying hospitals under this paragraph.

(1) Qualifying criteria. A hospital qualifies for the Iowa non-state-government-owned acute care teaching hospital disproportionate share payments if it qualifies for disproportionate share payments pursuant to paragraph 79.1(5) "y" and is an Iowa non-state-government-owned acute care teaching hospital located in a county with a population over 350,000.

(2) Amount of payment. The total amount of disproportionate share payments pursuant to paragraph 79.1(5) "y" and the Iowa non-state-government-owned acute care teaching hospital disproportionate share payments shall not exceed the amount of the state's allotment under Public Law 102-234. In addition, the total amount of all disproportionate share payments shall not exceed the hospital-specific disproportionate share limits under Public Law 103-666.

(3) Final disproportionate share adjustment. The department's total year-end disproportionate share obligations to a qualifying hospital will be calculated following completion of the desk review or audit of CMS 2552-96, Hospital and Healthcare Complex Cost Report. The department's total year-end disproportionate share obligation shall not exceed the difference between the following:

1. The annual amount appropriated to the IowaCare account for distribution to publicly owned acute care teaching hospitals located in a county with a population over 350,000; and

2. The actual IowaCare expansion population claims submitted and paid by the Iowa Medicaid enterprise to qualifying hospitals.

w. Rate adjustments for hospital mergers. When one or more hospitals merge to form a distinctly different legal entity, the base rate plus applicable add-ons will be revised to reflect this new entity. Financial information from the original cost reports and original rate calculations will be added together and averaged to form the new rate for that entity.

x. For cost reporting periods beginning on or after July 1, 1993, reportable Medicaid administrative and general expenses are allowable only to the extent that they are defined as allowable using Medicare Reimbursement Principles or Health Insurance Reimbursement Manual 15 (HIM-15). Appropriate, reportable costs are those that meet the Medicare (or HIM-15) principles, are reasonable, and are directly related to patient care. In instances where costs are not directly related to patient care or are not in accord with Medicare Principles of Reimbursement, inclusion of those costs in the cost report would not be appropriate. Examples of administrative and general costs that must be related to patient care to be included as a reportable cost in the report are:

- (1) Advertising.
- (2) Promotional items.
- (3) Feasibility studies.
- (4) Administrative travel and entertainment.
- (5) Dues, subscriptions, or membership costs.
- (6) Contributions made to other organizations.
- (7) Home office costs.
- (8) Public relations items.
- (9) Any patient convenience items.
- (10) Management fees for administrative services.
- (11) Luxury employee benefits (i.e., country club dues).
- (12) Motor vehicles for other than patient care.
- (13) Reorganization costs.

y. *Graduate medical education and disproportionate share fund.* Payment shall be made to hospitals in Iowa qualifying for direct medical education, indirect medical education, or disproportionate share payments directly from the graduate medical education and disproportionate share fund. The requirements to receive payments from the fund, the amounts allocated to the fund, and the methodology used to determine the distribution amounts from the fund are as follows:

(1) Qualifying for direct medical education. Iowa hospitals qualify for direct medical education payments if direct medical education costs that qualify for payment as medical education costs under the Medicare program are contained in the hospital's base year cost report and in the most recent cost report submitted before the start of the state fiscal year for which payments are being made. Out-of-state hospitals do not qualify for direct medical education payments.

(2) Allocation to fund for direct medical education. The total state fiscal year annual amount of funding that is allocated to the graduate medical education and disproportionate share fund for direct medical education related to inpatient services is \$7,594,294.03. If a hospital fails to qualify for direct medical education payments from the fund because the hospital does not report direct medical education costs that qualify for payment as medical education costs under the Medicare program in the most recent cost report submitted before the start of the state fiscal year for which payments are being made, the amount of money that would have been paid to that hospital shall be removed from the fund.

(3) Distribution to qualifying hospitals for direct medical education. Distribution of the amount in the fund for direct medical education shall be on a monthly basis. To determine the amount to be distributed to each qualifying hospital for direct medical education, the following formula is used:

1. Multiply the total of all DRG weights for claims paid from the GME/DSH fund apportionment claim set for each hospital reporting direct medical education costs that qualify for payment as medical education costs under the Medicare program in the hospital's base year cost report by each hospital's direct medical education rate to obtain a dollar value.

2. Sum the dollar values for each hospital, then divide each hospital's dollar value by the total dollar value, resulting in a percentage.

3. Multiply each hospital's percentage by the amount allocated for direct medical education to determine the payment to each hospital.

(4) Qualifying for indirect medical education. Iowa hospitals qualify for indirect medical education payments from the fund when they receive a direct medical education payment from Iowa Medicaid and qualify for indirect medical education payments from Medicare. Qualification for indirect medical

education payments is determined without regard to the individual components of the specific hospital's teaching program, state ownership, or bed size. Out-of-state hospitals do not qualify for indirect medical education payments.

(5) Allocation to fund for indirect medical education. The total state fiscal year annual amount of funding that is allocated to the graduate medical education and disproportionate share fund for indirect medical education related to inpatient services is \$13,450,285.14. If a hospital fails to qualify for indirect medical education payments from the fund because the hospital does not report direct medical education costs that qualify for payment as medical education costs under the Medicare program in the most recent cost report submitted before the start of the state fiscal year for which payments are being made, the amount of money that would have been paid to that hospital shall be removed from the fund.

(6) Distribution to qualifying hospitals for indirect medical education. Distribution of the amount in the fund for indirect medical education shall be on a monthly basis. To determine the amount to be distributed to each qualifying hospital for indirect medical education, the following formula is used:

1. Multiply the total of all DRG weights for claims paid from the GME/DSH fund apportionment claim set for each hospital reporting direct medical education costs that qualify for payment as medical education costs under the Medicare program in the hospital's base year cost report by each hospital's indirect medical education rate to obtain a dollar value.

2. Sum the dollar values for each hospital, then divide each hospital's dollar value by the total dollar value, resulting in a percentage.

3. Multiply each hospital's percentage by the amount allocated for indirect medical education to determine the payment to each hospital.

(7) Qualifying for disproportionate share. For months beginning with July 2002, hospitals qualify for disproportionate share payments from the fund when the hospital's low-income utilization rate exceeds 25 percent, when the hospital's Medicaid inpatient utilization rate exceeds one standard deviation from the statewide average Medicaid utilization rate, or when the hospital qualifies as a children's hospital under subparagraph (10). Information contained in the hospital's base year cost report is used to determine the hospital's low-income utilization rate and the hospital's Medicaid inpatient utilization rate.

1. For those hospitals that qualify for disproportionate share under both the low-income utilization rate definition and the Medicaid inpatient utilization rate definition, the disproportionate share percentage shall be the greater of (1) the product of 2½ percent multiplied by the number of standard deviations by which the hospital's own Medicaid inpatient utilization rate exceeds the statewide mean Medicaid inpatient utilization rate for all hospitals, or (2) 2½ percent.

2. For those hospitals that qualify for disproportionate share under the low-income utilization rate definition, but do not qualify under the Medicaid inpatient utilization rate definition, the disproportionate share percentage shall be 2½ percent.

3. For those hospitals that qualify for disproportionate share under the Medicaid inpatient utilization rate definition, but do not qualify under the low-income utilization rate definition, the disproportionate share percentage shall be the product of 2½ percent multiplied by the number of standard deviations by which the hospital's own Medicaid inpatient utilization rate exceeds the statewide mean Medicaid inpatient utilization rate for all hospitals.

4. For those hospitals that qualify for disproportionate share as a children's hospital, the disproportionate share percentage shall be the greater of (1) the product of 2½ percent multiplied by the number of standard deviations by which the Medicaid inpatient utilization rate for children under 18 years of age at the time of admission in all areas of the hospital where services are provided predominantly to children under 18 years of age exceeds the statewide mean Medicaid inpatient utilization rate for all hospitals, or (2) 2½ percent.

5. Additionally, a qualifying hospital other than a children's hospital must also have at least two obstetricians who have staff privileges at the hospital and who have agreed to provide obstetric services to Medicaid-eligible persons who are in need of obstetric services. In the case of a hospital located in a rural area as defined in Section 1886 of the Social Security Act, the term "obstetrician" includes any physician with staff privileges at the hospital to perform nonemergency obstetric procedures.

6. Out-of-state hospitals serving Iowa Medicaid patients qualify for disproportionate share payments from the fund based on their state Medicaid agency's calculation of the Medicaid inpatient utilization rate. The disproportionate share percentage is calculated using the number of standard deviations by which the hospital's own state Medicaid inpatient utilization rate exceeds the hospital's own statewide mean Medicaid inpatient utilization rate.

7. Hospitals qualify for disproportionate share payments from the fund without regard to the facility's status as a teaching facility or bed size.

8. Hospitals receiving reimbursement as critical access hospitals shall not qualify for disproportionate share payments from the fund.

(8) Allocation to fund for disproportionate share. The total state fiscal year annual amount of funding that is allocated to the graduate medical education and disproportionate share fund for disproportionate share payments is \$6,959,868.59. If a hospital fails to qualify for disproportionate share payments from the fund due to closure or for any other reason, the amount of money that would have been paid to that hospital shall be removed from the fund.

(9) Distribution to qualifying hospitals for disproportionate share. Distribution of the amount in the fund for disproportionate share shall be on a monthly basis. To determine the amount to be distributed to each qualifying hospital for disproportionate share, the following formula is used:

1. Multiply the total of all DRG weights for claims paid from the GME/DSH fund apportionment claim set for each hospital that met the qualifications during the fiscal year used to determine the hospital's low-income utilization rate and Medicaid utilization rate (or for children's hospitals, during the preceding state fiscal year) by each hospital's disproportionate share rate to obtain a dollar value. For any hospital that qualifies for a disproportionate share payment only as a children's hospital, only the DRG weights for claims paid for services rendered to patients under 18 years of age at the time of admission in all distinct areas of the hospital where services are provided predominantly to children under 18 years of age shall be used in this calculation.

2. Sum the dollar values for each hospital, then divide each hospital's dollar value by the total dollar value, resulting in a percentage.

3. Multiply each hospital's percentage by the amount allocated for disproportionate share to determine the payment to each hospital.

In compliance with Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991 (Public Law 102-234) and 1992 Iowa Acts, chapter 1246, section 13, the total of disproportionate share payments from the GME/DSH fund and supplemental disproportionate share of payments pursuant to paragraph 79.1(5) "u" or 79.1(5) "v" cannot exceed the amount of the federal cap under Public Law 102-234.

(10) Qualifying for disproportionate share as a children's hospital. A licensed hospital qualifies for disproportionate share payments as a children's hospital if the hospital provides services predominantly to children under 18 years of age or includes a distinct area or areas providing services predominantly to children under 18 years of age and has Medicaid utilization and low-income utilization rates of 1 percent or greater for children under 18 years of age at the time of admission in all distinct areas of the hospital where services are provided predominantly to children under 18 years of age. In addition, the hospital must be a voting member of the National Association of Children's Hospitals and Related Institutions for dates of service prior to October 1, 2014, or a member of the National Association of Children's Hospitals and Related Institutions for dates of service on or after October 1, 2014.

A hospital wishing to qualify for disproportionate share payments as a children's hospital for any state fiscal year beginning on or after July 1, 2002, must provide the following information to the Iowa Medicaid enterprise provider cost audit and rate setting unit within 20 business days of a request by the department:

1. Base year cost reports.

2. Medicaid claims data for children under the age of 18 at the time of admission to the hospital in all distinct areas of the hospital where services are provided predominantly to children under 18 years of age.

3. Other information needed to determine a disproportionate share rate encompassing the periods used to determine the disproportionate share rate and distribution amounts.

z. Final settlement for state-owned teaching hospital.

(1) Effective July 1, 2010, total annual payments to an Iowa state-owned hospital for inpatient and outpatient hospital services shall equal 100 percent of allowable medical assistance program costs, not to exceed the sum of the following:

1. Payments for inpatient hospital services calculated in accordance with subrule 79.1(5), plus
2. Payment for outpatient hospital services calculated in accordance with subrule 79.1(16), plus
3. \$9,900,000.

(2) One-twelfth of the \$9,900,000 increase in reimbursement shall be distributed to the hospital on a monthly basis.

(3) The Iowa Medicaid enterprise shall complete a final settlement based on the hospital's Medicare cost report. If the aggregate payments are less than the hospital's actual medical assistance program costs, no additional payment shall be made.

(4) If the sum of the inpatient hospital service payments plus outpatient hospital service payments plus the \$9,900,000 exceeds 100 percent of allowable inpatient and outpatient costs, the department shall request and collect from the hospital the amount by which payments exceed actual medical assistance program costs.

aa. Retrospective adjustment for critical access hospitals. Payments to critical access hospitals pursuant to paragraphs 79.1(5) "a" to "z" are subject to a retrospective adjustment equal to the difference between the reasonable costs of covered services provided to eligible fee-for-service Medicaid members (excluding members in managed care), based on the hospital's annual cost reports and Medicare cost principles, and the Medicaid fee-for-service reimbursement received pursuant to paragraphs 79.1(5) "a" to "z." Amounts paid before adjustment that exceed reasonable costs shall be recovered by the department.

(1) The base rate upon which the DRG payment is built shall be changed after any retrospective adjustment to reflect, as accurately as is possible, the reasonable costs of providing the covered service to eligible fee-for-service Medicaid members for the coming year using the most recent utilization as submitted to the Iowa Medicaid enterprise provider cost audit and rate setting unit and Medicare cost principles.

(2) Once a hospital begins receiving reimbursement as a critical access hospital, the prospective DRG base rate is not subject to inflation factors, rebasing, or recalibration as provided in paragraph 79.1(5) "k."

ab. Nonpayment for preventable conditions. Preventable conditions identified pursuant to this rule that develop during inpatient hospital treatment shall not be considered in determining reimbursement for such treatment.

(1) Coding. All diagnoses included on an inpatient hospital claim must include one of the following codes indicating whether the condition was present or developing at the time of the order for inpatient admission:

Present on Admission (POA) Indicator Codes

Code Explanation

- | | |
|---|--|
| Y | The condition was present or developing at the time of the order for inpatient admission. |
| N | The condition was not present or developing at the time of the order for inpatient admission. |
| U | Documentation is insufficient to determine whether the condition was present or developing at the time of the order for inpatient admission. |
| W | Clinically undetermined. The provider is clinically unable to determine whether or not the condition was present or developing at the time of the order for inpatient admission. |

(2) Payment processing. Claims will be processed according to the DRG methodology without consideration of any diagnosis identified by the Secretary of the United States Department of Health

and Human Services pursuant to Section 1886(d)(4)(D)(iv) of the Social Security Act (42 U.S.C. 1395ww(d)(4)(D)(iv)) if the condition was not present or developing at the time of the order for inpatient admission.

ac. Rural hospital disproportionate share payment. In addition to payments from the graduate medical education and disproportionate share fund made pursuant to paragraph 79.1(5)“y,” payment shall be made to qualifying Iowa hospitals that elect to participate in rural hospital disproportionate share payments. Interim monthly payments will be made based on the amount of state share that is transferred to the department.

(1) Qualifying criteria. A hospital that qualifies for disproportionate share payments pursuant to paragraph 79.1(5)“y” and that is a rural prospective payment hospital not designated as a critical access hospital qualifies for rural hospital disproportionate share payments.

(2) Source of nonfederal share. The required nonfederal share shall be funds generated from tax levy collections of the county or city in which the hospital is located, and is subject to the conditions specified in this subparagraph and applicable federal law and regulations.

1. The nonfederal share funds shall be distributed to the department prior to the issuance of any disproportionate share payment to a qualifying hospital.

2. The city or county providing the nonfederal share funds shall annually document and certify that the funds provided as the nonfederal share were generated from tax proceeds, and not from any other source including federal grants or another federal funding source.

3. The applicable federal matching rate for the fiscal year shall apply.

(3) Amount of payment. The total amount of disproportionate share payments made pursuant to paragraph 79.1(5)“y” and the rural hospital disproportionate share payments shall not exceed the amount of the state’s allotment under Public Law 102-234. In addition, the total amount of all disproportionate share payments shall not exceed the hospital-specific disproportionate share limits under Public Law 103-666.

(4) Final disproportionate share adjustment. Qualifying hospitals shall annually provide a disproportionate share hospital survey within the time frames specified by the department, for the purpose of calculating the hospital-specific disproportionate share limits under Public Law 103-666.

79.1(6) Independent laboratories. The maximum payment for clinical diagnostic laboratory tests performed by an independent laboratory will be the areawide fee schedule established by the Centers for Medicare and Medicaid Services (CMS). The fee schedule is based on the definition of laboratory procedures from the Physician’s Current Procedural Terminology (CPT) published by the American Medical Association. The fee schedules are adjusted annually by CMS to reflect changes in the Consumer Price Index for All Urban Consumers.

79.1(7) Physicians.

a. Fee schedule. The fee schedule is based on the definitions of medical and surgical procedures given in the most recent edition of Physician’s Current Procedural Terminology (CPT). Refer to 441—paragraph 78.1(2)“e” for the guidelines for immunization replacement.

b. Payment reduction for services rendered in facility settings. Rescinded IAB 10/30/13, effective 1/1/14.

c. Payment for primary care services. To the extent required by 42 U.S.C. § 1396a(a)(13)(C), primary care services furnished in calendar year 2013 or 2014 by a qualified primary care physician or under the supervision of a qualified primary care physician shall be paid as provided pursuant to subparagraphs (1) to (4) and (6) of this paragraph (79.1(7)“c”). Primary care services furnished on or after January 1, 2015, by a qualified primary care physician or under the supervision of a qualified primary care physician shall be paid as provided pursuant to subparagraphs (1) to (3), (5), and (7) of this paragraph (79.1(7)“c”).

(1) Primary care services eligible for payment pursuant to this paragraph (79.1(7)“c”) include:

1. Evaluation and management (E & M) services covered by Iowa Medicaid and designated in the healthcare common procedure coding system (HCPCS) as codes 99201 through 99499, or their successor codes; and

2. Vaccine administration services covered by Iowa Medicaid and designated in the healthcare common procedure coding system (HCPCS) as codes 90460, 90461, 90471, 90472, 90473 and 90474, or their successor codes.

(2) For purposes of this paragraph (79.1(7)“c”), a qualified primary care physician is a physician who:

1. Is certified by the American Board of Medical Specialties (ABMS), the American Board of Physician Specialties (ABPS) or the American Osteopathic Association (AOA) with a specialty designation of family medicine, general internal medicine, or pediatric medicine or with a subspecialty designation recognized by the certifying organization as a subspecialty of family medicine, general internal medicine, or pediatric medicine; or

2. Has furnished primary care services eligible for payment pursuant to this paragraph (79.1(7)“c”) equal to at least 60 percent of the Iowa Medicaid services for which the qualified primary care physician has submitted claims during the most recently completed calendar year or, for newly eligible physicians, the prior month (excluding claims not paid and claims for which Medicare is the primary payer).

(3) For payment to be made under this paragraph (79.1(7)“c”), the qualified primary care physician must have certified that the physician is a qualified primary care physician by submitting Form 470-5138, Iowa Medicaid Primary Care Physician Certification and Attestation for Primary Care Rate Increase, prior to the date of service or by April 1, 2013, for services rendered January 1, 2013, through April 1, 2013.

(4) Primary care services rendered in calendar year 2013 or 2014. Primary care services rendered in calendar year 2013 or 2014 that are eligible for payment pursuant to this rule shall be paid at the greater of:

1. The otherwise applicable Iowa Medicaid rate;

2. The applicable rate under Medicare Part B, in effect for services rendered on the first day of the calendar year;

3. The rate that would be applicable under Medicare Part B, in effect for services rendered on the first day of the calendar year, if the conversion factor under 42 U.S.C. § 1395w-4(d) were the conversion factor for 2009; or

4. If there is no applicable rate under Medicare Part B, the rate specified in a fee schedule established and announced by the federal Centers for Medicare and Medicaid Services, pursuant to 42 CFR § 447.405(a)(1).

(5) Primary care services rendered on or after January 1, 2015. Primary care services rendered on or after January 1, 2015, that are eligible for payment pursuant to this rule shall be paid at the greater of:

1. The otherwise applicable Iowa Medicaid rate;

2. The applicable rate under Medicare Part B in effect for services rendered on January 1, 2014;

3. The rate that would be applicable under Medicare Part B, in effect for services rendered on January 1, 2014, if the conversion factor under 42 U.S.C. § 1395w-4(d) were the conversion factor for 2009; or

4. If there is no applicable rate under Medicare Part B, the rate specified in a fee schedule established and announced by the federal Centers for Medicare and Medicaid Services, pursuant to 42 CFR § 447.405(a)(1), and in effect on June 30, 2014.

(6) Notwithstanding the foregoing provisions of this paragraph (79.1(7)“c”), payment for the administration of vaccines provided under the Vaccines for Children Program in calendar year 2013 or 2014 shall be limited to the lesser of:

1. The regional maximum administration fee under the Vaccines for Children Program; or

2. The applicable Medicare fee schedule rate for HCPCS code 90460 (or, if higher, the Medicare fee schedule rate for HCPCS code 90460 that would apply if the conversion factor under 42 U.S.C. § 1395w-4(d) were the conversion factor for 2009).

(7) Notwithstanding the foregoing provisions of this paragraph (79.1(7)“c”), payment for the administration of vaccines provided under the Vaccines for Children Program on or after January 1, 2015, shall be the lesser of:

1. The regional maximum administration fee under the Vaccines for Children Program in effect on June 30, 2014; or

2. The applicable Medicare fee schedule rate in effect on June 30, 2014, for HCPCS code 90460 (or, if higher, the Medicare fee schedule rate for HCPCS code 90460 rate that would apply if the conversion factor under 42 U.S.C. § 1395w-4(d) were the conversion factor for 2009).

79.1(8) Drugs. The amount of payment shall be based on several factors, subject to the upper limits in 42 CFR 447.500 to 447.520 as amended to May 16, 2012. The Medicaid program relies on information published by Medi-Span to classify drugs as brand-name or generic. Specialty drugs include biological drugs, blood-derived products, complex molecules, and select oral, injectable, and infused medications identified by the department and published on the specialty drug list.

a. Until February 1, 2013, or federal approval of the reimbursement methodology provided in paragraph 79.1(8) “*c*,” whichever is later, reimbursement for covered generic prescription drugs shall be the lowest of the following, as of the date of dispensing:

(1) The estimated acquisition cost, defined:

1. For covered nonspecialty generic prescription drugs, as the average wholesale price as published by Medi-Span less 12 percent, plus the professional dispensing fee specified in paragraph 79.1(8) “*i*”; or

2. For covered specialty generic prescription drugs, as the average wholesale price as published by Medi-Span less 17 percent, plus the professional dispensing fee specified in paragraph 79.1(8) “*i*.”

(2) The maximum allowable cost (MAC), defined as the upper limit for multiple source drugs established in accordance with the methodology of the Centers for Medicare and Medicaid Services as described in 42 CFR 447.514, plus the professional dispensing fee specified in paragraph 79.1(8) “*i*.”

(3) The state maximum allowable cost (SMAC), defined as the average wholesale acquisition cost for a generic drug (the average price pharmacies pay to obtain the generic drug as evidenced by purchase records) adjusted by a multiplier of 1.2, plus the professional dispensing fee specified in paragraph 79.1(8) “*i*.”

(4) The submitted charge, representing the provider’s usual and customary charge for the drug.

b. Until February 1, 2013, or federal approval of the reimbursement methodology provided in paragraph 79.1(8) “*d*,” whichever is later, reimbursement for covered brand-name prescription drugs shall be the lower of the following, as of the date of dispensing:

(1) The estimated acquisition cost, defined:

1. For covered nonspecialty brand-name prescription drugs, as the average wholesale price as published by Medi-Span less 12 percent, plus the professional dispensing fee specified in paragraph 79.1(8) “*i*”; or

2. For covered specialty brand-name prescription drugs, as the average wholesale price as published by Medi-Span less 17 percent, plus the professional dispensing fee specified in paragraph 79.1(8) “*i*.”

(2) The submitted charge, representing the provider’s usual and customary charge for the drug.

c. Effective February 1, 2013, or upon federal approval, whichever is later, reimbursement for covered generic prescription drugs and for covered nonprescription drugs shall be the lowest of the following, as of the date of dispensing:

(1) The average actual acquisition cost (AAC), determined pursuant to paragraph 79.1(8) “*k*,” plus the professional dispensing fee determined pursuant to paragraph 79.1(8) “*j*.”

(2) The maximum allowable cost (MAC), defined as the specific upper limit for multiple source drugs established in accordance with the methodology of the Centers for Medicare and Medicaid Services as described in 42 CFR 447.514, plus the professional dispensing fee determined pursuant to paragraph 79.1(8) “*j*.”

(3) The submitted charge, representing the provider’s usual and customary charge for the drug.

d. Effective February 1, 2013, or upon federal approval, whichever is later, reimbursement for covered brand-name prescription drugs shall be the lower of the following, as of the date of dispensing:

(1) The average actual acquisition cost (AAC), determined pursuant to paragraph 79.1(8) “*k*,” plus the professional dispensing fee determined pursuant to paragraph 79.1(8) “*j*.”

- (2) The submitted charge, representing the provider's usual and customary charge for the drug.
 - e.* No payment shall be made for sales tax.
 - f.* All hospitals that wish to administer vaccines which are available through the Vaccines for Children Program to Medicaid members shall enroll in the Vaccines for Children Program. In lieu of payment, vaccines available through the Vaccines for Children Program shall be accessed from the department of public health for Medicaid members. Hospitals receive reimbursement for the administration of vaccines to Medicaid members through the DRG reimbursement for inpatients and APC reimbursement for outpatients.
 - g.* Until February 1, 2013, or federal approval of the reimbursement methodology provided in paragraph 79.1(8)"c," whichever is later, the basis of payment for nonprescription drugs shall be the same as specified in paragraph 79.1(8)"a" except that the department shall establish a maximum allowable reimbursable cost for these drugs using the average wholesale prices of the chemically equivalent products available. The department shall set the maximum allowable reimbursable cost at the median of those average wholesale prices. No exceptions for higher reimbursement will be approved.
 - h.* An additional reimbursement amount of one cent per dose shall be added to the allowable cost of a prescription for an oral solid if the drug is dispensed to a patient in a nursing home in unit dose packaging prepared by the pharmacist.
 - i.* Rescinded IAB 6/11/14, effective 8/1/14.
 - j.* The professional dispensing fee shall be a fee schedule amount determined by the department based on a survey of Iowa Medicaid participating pharmacy providers' costs of dispensing drugs to Medicaid beneficiaries conducted every two years beginning in SFY 2014-2015.
 - k.* For purposes of this rule, average actual acquisition cost (AAC) is defined as retail pharmacies' average prices paid to acquire drug products. Average AAC shall be determined by the department based on a survey of invoice prices paid by Iowa Medicaid retail pharmacies. Surveys shall be conducted at least once every six months, or more often at the department's discretion. The average AAC shall be calculated as a statistical mean based on one reported cost per drug per pharmacy. The average AAC determined by the department shall be published on the Iowa Medicaid enterprise Web site. If no current average AAC has been determined for a drug, the wholesale acquisition cost (WAC) published by Medi-Span shall be used as the average AAC.
 - l.* For purposes of this subrule, "equivalent products" shall be those that meet therapeutic equivalent standards as published in the federal Food and Drug Administration document, "Approved Prescription Drug Products With Therapeutic Equivalence Evaluations."
 - m.* Savings in Medicaid reimbursements attributable to the SMAC shall be used to pay costs associated with determination of the SMAC, before reversion to Medicaid.
 - n.* Payment to physicians for physician-administered drugs billed with healthcare common procedure coding system (HCPCS) Level II "J" codes, as a physician service, shall be pursuant to physician payment policy under subrule 79.1(2).
- 79.1(9) HCBS consumer choices financial management.**
- a. Monthly allocation.* A financial management service provider shall receive a monthly fee as established in subrule 79.1(2) for each consumer electing to work with that provider under the HCBS consumer choices option. The financial management service provider shall also receive monthly the consumer's individual budget amount as determined under 441—paragraph 78.34(13)"b," 78.37(16)"b," 78.38(9)"b," 78.41(15)"b," 78.43(15)"b," or 78.46(6)"b."
 - b. Cost settlement.* The financial management service shall pay from the monthly allocated individual budget amount for independent support broker service, self-directed personal care services, individual-directed goods and services, and self-directed community supports and employment as authorized by the consumer. On a quarterly basis during the federal fiscal year, the department shall perform a cost settlement. The cost settlement represents the difference between the amount received for the allocated individual budget and the amount actually utilized.
 - c. Start-up grants.* A qualifying financial management service provider may be reimbursed up to \$10,000 for the costs associated for starting the service.

(1) Start-up reimbursement shall be issued as long as funds for this purpose are available from the Robert Wood Johnson Foundation or until September 30, 2007.

(2) Funds will not be distributed until the provider meets all of the following criteria:

1. The provider shall meet the requirements to be certified to participate in an HCBS waiver program as set forth in 441—subrule 77.30(13), 77.33(16), 77.34(9), 77.37(28), 77.39(26), or 77.41(7), including successful completion of a readiness review as approved by the department.

2. The provider shall enter into an agreement with the department to provide statewide coverage for not less than one year from the date that the funds are distributed.

3. The provider shall submit to the department for approval a budget identifying the costs associated with starting financial management service.

(3) If the provider fails to continue to meet these qualifications after the funds have been distributed, the department may recoup all or part of the funds paid to the provider.

79.1(10) *Prohibition against reassignment of claims.* No payment under the medical assistance program for any care or service provided to a patient by any health care provider shall be made to anyone other than the providers. However with respect to physicians, dentists or other individual practitioners direct payment may be made to the employer of the practitioner if the practitioner is required as a condition of employment to turn over fees to the employer; or where the care or service was provided in a facility, to the facility in which the care or service was provided if there is a contractual arrangement between the practitioner and the facility whereby the facility submits the claim for reimbursement; or to a foundation, plan or similar organization including a health maintenance organization which furnishes health care through an organized health care delivery system if there is a contractual agreement between organization and the person furnishing the service under which the organization bills or receives payment for the person's services. Payment may be made in accordance with an assignment from the provider to a government agency or an assignment made pursuant to a court order. Payment may be made to a business agent, such as a billing service or accounting firm, which renders statements and receives payment in the name of the provider when the agent's compensation for this service is (1) reasonably related to the cost or processing the billing; (2) not related on a percentage or other basis to the dollar amounts to be billed or collected; and (3) not dependent upon the actual collection of payment. Nothing in this rule shall preclude making payment to the estate of a deceased practitioner.

79.1(11) *Prohibition against factoring.* Payment under the medical assistance program for any care or service furnished to an individual by providers as specified in 79.1(1) shall not be made to or through a factor either directly or by virtue of power of attorney given by the provider to the factor. A factor is defined as an organization, collection agency, or service bureau which, or an individual who, advances money to a provider for accounts receivable which have been assigned or sold or otherwise transferred including transfer through the use of power of attorney to the organization or individual for an added fee or reduction of a portion of the accounts receivable. The term factor does not include business representatives such as billing agents or accounting firms which render statements and receive payments in the name of the individual provider provided that the compensation of the business representative for the service is reasonably related to the cost of processing the billings and is not related on a percentage or other basis to the dollar amounts to be billed or collected.

79.1(12) *Reasonable charges for services, supplies, and equipment.* For selected medical services, supplies, and equipment, including equipment servicing, which in the judgment of the Secretary of the Department of Health and Human Services generally do not vary significantly in quality from one provider to another, the upper limits for payments shall be the lowest charges for which the devices are widely and consistently available in a locality. For those selected services and items furnished under Part B of Medicare and Medicaid, the upper limits shall be the lowest charge levels recognized under Medicare. For those selected services and items furnished only under Medicaid, the upper limits shall be the lowest charge levels determined by the department according to the Medicare reimbursement method.

a. For any noninstitutional item or service furnished under both Medicare and Medicaid, the department shall pay no more than the reasonable charge established for that item or service by the Part

B Medicare carrier serving part or all of Iowa. Noninstitutional services do not include practitioner's services, such as physicians, pharmacies, or out-patient hospital services.

b. For all other noninstitutional items or services furnished only under Medicaid, the department shall pay no more than the customary charge for a provider or the prevailing charges in the locality for comparable items or services under comparable circumstances, whichever is lower.

79.1(13) Copayment by member. A copayment in the amount specified shall be charged to members for the following covered services:

a. The member shall pay a copayment for each covered prescription or refill of any covered drug as follows:

(1) One dollar for generic drugs and preferred brand-name drugs. Any brand-name drug that is not subject to prior approval based on nonpreferred status on the preferred drug list published by the department pursuant to Iowa Code section 249A.20A shall be treated as a preferred brand-name drug.

(2) Rescinded IAB 7/6/05, effective 7/1/05.

(3) One dollar for nonpreferred brand-name drugs for which the cost to the state is less than \$25.

(4) Two dollars for nonpreferred brand-name drugs for which the cost to the state is \$25.01 to \$50.

(5) Three dollars for nonpreferred brand-name drugs for which the cost to the state is \$50.01 or more.

(6) For the purpose of this paragraph, the cost to the state is determined without regard to federal financial participation in the Medicaid program or to any rebates received.

b. The member shall pay \$1 copayment for total covered service rendered on a given date for podiatrists' services, chiropractors' services, and services of independently practicing physical therapists.

c. The member shall pay \$2 copayment for total covered services rendered on a given date for medical equipment and appliances, prosthetic devices and medical supplies as defined in 441—78.10(249A), orthopedic shoes, services of audiologists, services of hearing aid dealers except the hearing aid, services of optometrists, opticians, rehabilitation agencies, and psychologists, and ambulance services.

d. The member shall pay \$3 copayment for:

(1) Total covered service rendered on a given date for dental services and hearing aids.

(2) All covered services rendered in a physician office visit on a given date. For the purposes of this subparagraph, "physician" means either a doctor of allopathic medicine (M.D.) or a doctor of osteopathic medicine (D.O.), as defined under rule 441—77.1(249A).

e. Copayment charges are not applicable to persons under age 21.

f. Copayment charges are not applicable to family planning services or supplies.

g. Copayment charges are not applicable for a member receiving inpatient care in a hospital, nursing facility, state mental health institution, or other medical institution if the person is required, as a condition of receiving services in the institution, to spend for costs of necessary medical care all but a minimal amount of income for personal needs.

h. The member shall pay \$1 for each federal Medicare Part B crossover claim submitted to the Medicaid program when the services provided have a Medicaid copayment as set forth above.

i. Copayment charges are not applicable to services furnished pregnant women.

j. All providers are prohibited from offering or providing copayment related discounts, rebates, or similar incentives for the purpose of soliciting the patronage of Medicaid members.

k. Copayment charges are not applicable for emergency services. Emergency services are defined as services provided in a hospital, clinic, office, or other facility that is equipped to furnish the required care, after the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain), that the absence of immediate medical attention could reasonably be expected to result in:

(1) Placing the patient's health in serious jeopardy,

(2) Serious impairment to bodily functions, or

(3) Serious dysfunction of any bodily organ or part.

l. Copayment charges are not applicable for services rendered by a health maintenance organization in which the member is enrolled.

m. No provider of service participating in the Medicaid program may deny care or services to a person eligible for care or services under the program because of the person's inability to pay a copayment. However, this rule does not change the fact that a member is liable for the charges and it does not preclude the provider from attempting to collect them.

n. The member shall pay a \$3 copayment for each visit to a hospital emergency room for treatment that does not meet the criteria for an emergency service as defined in paragraph 79.1(13) "*k.*" This \$3 copayment shall not apply if the visit to the emergency room results in a hospital admission.

79.1(14) *Reimbursement for hospice services.*

a. Medicaid hospice rates. The Medicaid hospice rates are based on the methodology used in setting Medicare rates, adjusted to disregard cost offsets attributable to Medicare coinsurance amounts, and with application of the appropriate area wage adjustments for the categories of care provided.

Hospices are reimbursed at one of four predetermined rates based on the level of care furnished to the individual for that day. Payments to a hospice for inpatient care are subject to the limitations imposed by Medicare. The levels of care into which each day of care is classified are as follows:

- (1) Routine home care.
- (2) Continuous home care.
- (3) Inpatient respite care.
- (4) General inpatient care.

b. Adjustment to hospice rates. An adjustment to hospice reimbursement is made when a recipient residing in a nursing facility elects the hospice benefit. The adjustment will be a room and board rate that is equal to the rate at which the facility is paid for reserved bed days or 95 percent of the facility's Medicaid reimbursement rate, whichever is greater. Room and board services include the performance of personal care services, including assistance in activities of daily living, socializing activities, administration of medication, maintaining the cleanliness of a resident's room and supervising and assisting in the use of durable medical equipment and prescribed therapies.

For hospice recipients entering a nursing facility the adjustment will be effective the date of entry. For persons in nursing facilities prior to hospice election, the adjustment rate shall be effective the date of election.

For individuals who have client participation amounts attributable to their cost of care, the adjustment to the hospice will be reduced by the amount of client participation as determined by the department. The hospice will be responsible for collecting the client participation amount due the hospice unless the hospice and the nursing facility jointly determine the nursing facility is to collect the client participation.

c. Payment for day of discharge. For the day of discharge from an inpatient unit, the appropriate home care rate is to be paid unless the recipient dies as an inpatient. When the recipient is discharged as deceased, the inpatient rate (general or respite) is to be paid for the discharge date.

d. Hospice cap. Overall aggregate payments made to a hospice during a hospice cap period are limited or capped. The hospice cap year begins November 1 and ends October 31 of the next year. The cap amount for each hospice is calculated by multiplying the number of beneficiaries electing hospice care from that hospice during the cap period by the base statutory amount, adjusted to reflect the percentage increase or decrease in the medical care expenditure category of the Consumer Price Index for all urban consumers published by the Bureau of Labor Statistics. Payments made to a hospice but not included in the cap include room and board payment to a nursing home. Any payment in excess of the cap must be refunded to the department by the hospice.

e. Limitation of payments for inpatient care. Payments to a hospice for inpatient care shall be limited according to the number of days of inpatient care furnished to Medicaid patients. During the 12-month period beginning November 1 of each year and ending October 31, the aggregate number of inpatient days (both for general inpatient care and inpatient respite care) shall not exceed 20 percent of the aggregate total number of days of hospice care provided to all Medicaid recipients during that same period. Medicaid recipients afflicted with acquired immunodeficiency syndrome (AIDS) are excluded in calculating this inpatient care limitation. This limitation is applied once each year, at the end of the

hospices' "cap period" (November 1 to October 31). For purposes of this computation, if it is determined that the inpatient rate should not be paid, any days for which the hospice receives payment at a home care rate will not be counted as inpatient days. The limitation is calculated as follows:

(1) The maximum allowable number of inpatient days will be calculated by multiplying the total number of days of Medicaid hospice care by 0.2.

(2) If the total number of days of inpatient care furnished to Medicaid hospice patients is less than or equal to the maximum, no adjustment will be necessary.

(3) If the total number of days of inpatient care exceeded the maximum allowable number, the limitation will be determined by:

1. Calculating a ratio of the maximum allowable days to the number of actual days of inpatient care, and multiplying this ratio by the total reimbursement for inpatient care (general inpatient and inpatient respite reimbursement) that was made.

2. Multiplying excess inpatient care days by the routine home care rate.

3. Adding together the amounts calculated in "1" and "2."

4. Comparing the amount in "3" with interim payments made to the hospice for inpatient care during the "cap period."

Any excess reimbursement shall be refunded by the hospice.

f. Location of services. Claims must identify the geographic location where the service is provided (as distinct from the location of the hospice).

79.1(15) HCBS retrospectively limited prospective rates. This methodology applies to reimbursement for HCBS supported community living; HCBS family and community support services; HCBS supported employment enhanced job search activities; and HCBS interim medical monitoring and treatment when provided by an HCBS-certified supported community agency.

a. Reporting requirements.

(1) Providers shall submit cost reports for each waiver service provided using Form 470-0664, Financial and Statistical Report for Purchase of Service, and Form 470-3449, Supplemental Schedule. The cost reporting period is from July 1 to June 30. The completed cost reports shall be submitted to the IME Provider Cost Audits and Rate Setting Unit, P.O. Box 36450, Des Moines, Iowa 50315, or by electronic mail to costaudit@dhs.state.ia.us, by September 30 of each year.

(2) If a provider chooses to leave the HCBS program or terminates a service, a final cost report shall be submitted within 60 days of termination for retrospective adjustment.

(3) Costs reported under the waiver shall not be reported as reimbursable costs under any other funding source. Costs incurred for other services shall not be reported as reimbursable costs under the waiver.

(4) Financial information shall be based on the agency's financial records. When the records are not kept on an accrual basis of accounting, the provider shall make the adjustments necessary to convert the information to an accrual basis for reporting. Providers which are multiple program agencies shall submit a cost allocation schedule, prepared in accordance with generally accepted accounting principles.

(5) Failure to maintain records to support the cost reports may result in termination of the provider's HCBS certification.

(6) The department may require that an opinion of a certified public accountant or public accountant accompany the report when adjustments made to prior reports indicate noncompliance with reporting instructions.

(7) A 30-day extension for submitting the cost reports due by September 30 may be obtained by submitting a letter to the bureau of long-term care by September 30. No extensions will be granted beyond 30 days.

(8) Failure to submit a report that meets the requirements of this paragraph by September 30 or an extended deadline granted per subparagraph (7) shall reduce payment to 76 percent of the current rate. The reduced rate shall be paid for not longer than three months, after which time no further payments will be made.

b. Home- and community-based general rate criteria.

(1) To receive reimbursement for services, a certified provider shall enter into an agreement with the department on Form 470-2918, HCBS Waiver Agreement, and have an approved service plan for the consumer.

(2) The rates a provider may charge are subject to limits established in subrule 79.1(2).

(3) Indirect administrative costs shall be limited to 20 percent of other costs.

(4) Mileage costs shall be reimbursed according to state employee rate.

(5) Consumer transportation, consumer consulting, consumer instruction, consumer environmental modification and repairs and consumer environmental furnishings shall not exceed \$1,570 per consumer per year for supported community living services.

(6) For respite care provided in the consumer's home, only the cost of care is reimbursed.

(7) For respite care provided outside the consumer's home, charges may include room and board.

(8) Transportation and therapeutic resources reimbursement shall not exceed \$1,500 per child per year for family and community support services.

c. Prospective rates for new providers.

(1) Providers who have not submitted an annual report including at least 6 months of actual, historical costs shall be paid prospective rates based on projected reasonable and proper costs of operation for a 12-month period reported in Form SS-1703-0, Financial and Statistical Report, and Form 470-3449, Supplemental Schedule.

(2) Prospective rates shall be subject to retrospective adjustment as provided in paragraph "e."

(3) After a provider has submitted an annual report including at least six months of actual, historical costs, prospective rates shall be determined as provided in paragraph "d."

d. Prospective rates for established providers.

(1) Providers who have submitted an annual report including at least six months of actual, historical costs shall be paid prospective rates based on reasonable and proper costs in a base period, as adjusted for inflation.

(2) The base period shall be the period covered by the first Form SS-1703-0, Financial and Statistical Report, and Form 470-3449, Supplemental Schedule, submitted to the department after 1997 that includes at least six months of actual, historical costs.

(3) Reasonable and proper costs in the base period shall be inflated by a percentage of the increase in the consumer price index for all urban consumers for the preceding 12-month period ending June 30, based on the months included in the base period, to establish the initial prospective rate for an established provider.

(4) After establishment of the initial prospective rate for an established provider, the rate will be adjusted annually, effective for the third month after the month during which the annual cost report is submitted to the department. The provider's new rate shall be the actual reconciled rate or the previously established rate adjusted by the consumer price index for all urban consumers for the preceding 12-month period ending June 30, whichever is less.

(5) Prospective rates for services other than respite shall be subject to retrospective adjustment as provided in paragraph "f."

e. Prospective rates for respite. Rescinded IAB 5/1/13, effective 7/1/13.

f. Retrospective adjustments.

(1) Retrospective adjustments shall be made based on reconciliation of provider's reasonable and proper actual service costs with the revenues received for those services as reported on Form 470-3449, Supplemental Schedule, accompanying Form SS-1703-0, Financial and Statistical Report for Purchase of Service.

(2) Revenues exceeding adjusted actual costs by more than 4.5 percent shall be remitted to the department. Payment will be due upon notice of the new rates and retrospective rate adjustment.

(3) Providers who do not reimburse revenues exceeding 104.5 percent of actual costs 30 days after notice is given by the department will have the revenues over 104.5 percent of the actual costs deducted from future payments.

g. Supported community living daily rate. For purposes of determining the daily rate for supported community living services, providers are treated as new providers until they have submitted an annual

report including at least six months of actual costs for the same consumers at the same site with no significant change in any consumer's needs, or if there is a subsequent change in the consumers at a site or in any consumer's needs. Individual prospective daily rates are determined for each consumer. These rates may be adjusted no more than once every three months if there is a vacancy at the site for over 30 days or the consumer's needs have significantly changed. Rates adjusted on this basis will become effective the month a new cost report is submitted. Retrospective adjustments of the prospective daily rates are based on each site's average costs.

79.1(16) Outpatient reimbursement for hospitals.

a. Definitions.

"Allowable costs" means the costs defined as allowable in 42 CFR, Chapter IV, Part 413, as amended to October 1, 2007, except for the purposes of calculating direct medical education costs, where only the reported costs of the interns and residents are allowed. Further, costs are allowable only to the extent that they relate to patient care; are reasonable, ordinary, and necessary; and are not in excess of what a prudent and cost-conscious buyer would pay for the given service or item.

"Ambulatory payment classification" or *"APC"* means an outpatient service or group of services for which a single rate is set. The services or groups of services are determined according to the typical clinical characteristics, the resource use, and the costs associated with the service or services.

"Ambulatory payment classification relative weight" or *"APC relative weight"* means the relative value assigned to each APC.

"Ancillary service" means a supplemental service that supports the diagnosis or treatment of the patient's condition. Examples include diagnostic testing or screening services and rehabilitative services such as physical or occupational therapy.

"APC service" means a service that is priced and paid using the APC system.

"Base year cost report," for rates effective January 1, 2009, means the hospital's cost report with fiscal year end on or after January 1, 2007, and before January 1, 2008. Cost reports shall be reviewed using Medicare's cost reporting and cost reimbursement principles for those cost reporting periods.

"Blended base APC rate" shall mean the hospital-specific base APC rate, plus the statewide base APC rate, divided by two. The costs of hospitals receiving reimbursement as critical access hospitals during any of the period included in the base-year cost report shall not be used in determining the statewide base APC rate.

"Case-mix index" shall mean an arithmetical index measuring the relative average costliness of outpatient cases treated in a hospital, compared to the statewide average.

"Cost outlier" shall mean services provided during a single visit that have an extraordinarily high cost as established in paragraph "g" and are therefore eligible for additional payments above and beyond the base APC payment.

"Current procedural terminology—fourth edition (CPT-4)" is the systematic listing and coding of procedures and services provided by physicians or other related health care providers. The CPT-4 coding is maintained by the American Medical Association and is updated yearly.

"Diagnostic service" means an examination or procedure performed to obtain information regarding the medical condition of an outpatient.

"Direct medical education costs" shall mean costs directly associated with the medical education of interns and residents or other medical education programs, such as a nursing education program or allied health programs, conducted in an outpatient setting, that qualify for payment as medical education costs under the Medicare program. The amount of direct medical education costs is determined from the hospital base-year cost reports and is inflated in determining the direct medical education rate.

"Direct medical education rate" shall mean a rate calculated for a hospital reporting medical education costs on the Medicare cost report (CMS 2552). The rate is calculated using the following formula: Direct medical education costs are multiplied by the percentage of valid claims to total claims, further multiplied by inflation factors, then divided by outpatient visits.

"Discount factor" means the percentage discount applied to additional APCs when more than one APC is provided during the same visit (including the same APC provided more than once). Not all APCs are subject to a discount factor.

“GME/DSH fund apportionment claim set” means the hospital’s applicable Medicaid claims paid from July 1, 2008, through June 30, 2009. The claim set is updated every three years in July.

“GME/DSH fund implementation year” means 2009.

“Graduate medical education and disproportionate share fund” or *“GME/DSH fund”* means a reimbursement fund developed as an adjunct reimbursement methodology to directly reimburse qualifying hospitals for the direct costs of interns and residents associated with the operation of graduate medical education programs for outpatient services.

“Healthcare common procedures coding system” or *“HCPCS”* means the national uniform coding method that is maintained by the Centers for Medicare and Medicaid Services (CMS) and that incorporates the American Medical Association publication Physicians Current Procedural Terminology (CPT) and the three HCPCS unique coding levels I, II, and III.

“Hospital-based clinic” means a clinic that is owned by the hospital, operated by the hospital under its hospital license, and on the premises of the hospital.

“International classifications of diseases—fourth edition, ninth revision (ICD-9)” is a systematic method used to classify and provide standardization to coding practices which are used to describe the diagnosis, symptom, complaint, condition or cause of a person’s injury or illness.

“Medicaid claim set” means the hospital’s applicable Medicaid claims for the period of January 1, 2006, through December 31, 2007, and paid through March 31, 2008.

“Modifier” means a two-character code that is added to the procedure code to indicate the type of service performed. The modifier allows the reporting hospital to indicate that a performed service or procedure has been altered by some specific circumstance. The modifier may affect payment or may be used for information only.

“Multiple significant procedure discounting” means a reduction of the standard payment amount for an APC to recognize that the marginal cost of providing a second APC service to a patient during a single visit is less than the cost of providing that service by itself.

“Observation services” means a set of clinically appropriate services, such as ongoing short-term treatment, assessment, and reassessment, that is provided before a decision can be made regarding whether a patient needs further treatment as a hospital inpatient or is able to be discharged from the hospital.

“Outpatient hospital services” means preventive, diagnostic, therapeutic, observation, rehabilitation, or palliative services provided to an outpatient by or under the direction of a physician, dentist, or other practitioner by an institution that:

1. Is licensed or formally approved as a hospital by the officially designated authority in the state where the institution is located; and
2. Meets the requirements for participation in Medicare as a hospital.

“Outpatient prospective payment system” or *“OPPS”* means the payment methodology for hospital outpatient services established by this subrule and based on Medicare’s outpatient prospective payment system mandated by the Balanced Budget Refinement Act of 1999 and the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000.

“Outpatient visit” shall mean those hospital-based outpatient services which are billed on a single claim form.

“Packaged service” means a service that is secondary to other services but is considered an integral part of another service.

“Pass-through” means certain drugs, devices, and biologicals for which providers are entitled to payment separate from any APC.

“Quality improvement organization” or *“QIO”* shall mean the organization that performs medical peer review of Medicaid claims, including review of validity of hospital diagnosis and procedure coding information; completeness, adequacy and quality of care; and appropriateness of prospective payments for outlier cases and nonemergent use of the emergency room. These activities undertaken by the QIO may be included in a contractual relationship with the Iowa Medicaid enterprise.

“Rebasing” shall mean the redetermination of the blended base APC rate using more recent Medicaid cost report data.

“*Significant procedure*” shall mean the procedure, therapy, or service provided to a patient that constitutes the primary reason for the visit and dominates the time and resources expended during the visit.

“*Status indicator*” or “*SI*” means a payment indicator that identifies whether a service represented by a CPT or HCPCS code is payable under the OPPS APC or another payment system. Only one status indicator is assigned to each CPT or HCPCS code.

b. Outpatient hospital services. Medicaid adopts the Medicare categories of hospitals and services subject to and excluded from the hospital outpatient prospective payment system (OPPS) at 42 CFR 419.20 through 419.22 as amended to October 1, 2007, except as indicated in this subrule.

(1) A teaching hospital that has approval from the Centers for Medicare and Medicaid Services to receive reasonable cost reimbursement for physician services under 42 CFR 415.160 through 415.162 as amended to October 1, 2007, is eligible for combined billing status if the hospital has filed the approval notice with the Iowa Medicaid enterprise provider cost audit and rate setting unit. If a teaching hospital elects to receive reasonable cost payment for physician direct medical and surgical services furnished to Medicaid members, those services and the supervision of interns and residents furnishing the care to members are covered as hospital services and are combined with the bill for hospital service. Cost settlement for the reasonable costs related to physician direct medical and surgical services shall be made after receipt of the hospital’s financial and statistical report.

(2) A hospital-based ambulance service must be an enrolled Medicaid ambulance provider and must bill separately for ambulance services. EXCEPTION: If the member’s condition results in an inpatient admission to the hospital, the reimbursement for ambulance services is included in the hospital’s DRG reimbursement rate for the inpatient services.

(3) All psychiatric services for members who have a primary diagnosis of mental illness and are enrolled in the Iowa Plan program under 441—Chapter 88 shall be the responsibility of the Iowa Plan contractor and shall not be otherwise payable by Iowa Medicaid. The only exceptions to this policy are reference laboratory and radiology services, which will be payable by fee schedule or APC.

(4) Emergency psychiatric evaluations for members who are covered by the Iowa Plan shall be the responsibility of the Iowa Plan contractor. For members who are not covered by the Iowa Plan, services shall be payable under the APC for emergency psychiatric evaluation.

(5) Substance abuse services for persons enrolled in the Iowa Plan program under 441—Chapter 88 shall be the responsibility of the Iowa Plan contractor and shall not be otherwise payable by Iowa Medicaid. The only exceptions to this policy are reference laboratory and radiology services, which will be payable by fee schedule or APC.

c. Payment for outpatient hospital services.

(1) Outpatient hospital services shall be reimbursed according to the first of the following methodologies that applies to the service:

1. Any specific rate or methodology established by rule for the particular service.
2. The OPPS APC rates established pursuant to this subrule.
3. Fee schedule rates established pursuant to paragraph 79.1(1)“c.”

(2) Except as provided in paragraph 79.1(16)“h,” outpatient hospital services that have been assigned to an APC with an assigned weight shall be reimbursed based on the APC to which the services provided are assigned. The department adopts and incorporates by reference the OPPS APCs and relative weights effective January 1, 2008, published on November 27, 2007, as final by the Centers for Medicare and Medicaid Services in the Federal Register at Volume 72, No. 227, page 66579. Relative weights and APCs shall be updated pursuant to paragraph 79.1(16)“j.”

(3) The APC payment is calculated as follows:

1. The applicable APC relative weight is multiplied by the blended base APC rate determined according to paragraph 79.1(16)“e.”
2. The resulting APC payment is multiplied by a discount factor of 50 percent and by units of service when applicable.
3. For a procedure started but discontinued before completion, the department will pay 50 percent of the APC for the service.

(4) The OPPS APC payment status indicators show whether a service represented by a CPT or HCPCS code is payable under an OPPS APC or under another payment system and whether particular OPPS policies apply to the code. The following table lists the status indicators and definitions for both services that are paid under an OPPS APC and services that are not paid under an OPPS APC.

Indicator	Item, Code, or Service	OPPS Payment Status
A	<p>Services furnished to a hospital outpatient that are paid by Medicare under a fee schedule or payment system other than OPPS, such as:</p> <ul style="list-style-type: none"> • Ambulance services. • Clinical diagnostic laboratory services. • Diagnostic mammography. • Screening mammography. • Nonimplantable prosthetic and orthotic devices. • Physical, occupational, and speech therapy. • Erythropoietin for end-stage renal dialysis (ESRD) patients. • Routine dialysis services provided for ESRD patients in a certified dialysis unit of a hospital. 	<p>For services covered by Iowa Medicaid as an outpatient hospital service, the service is not paid under OPPS APC, but is paid based on the Iowa Medicaid fee schedule for outpatient hospital services established pursuant to 79.1(1) "c."</p> <p>For services not covered by Iowa Medicaid as an outpatient hospital service, the service is not paid under OPPS APC, but may be paid by Iowa Medicaid under the specific rate or methodology established by other rules (other than outpatient hospital).</p>
B	Codes that are not paid by Medicare on an outpatient hospital basis	<p>Not paid under OPPS APC.</p> <ul style="list-style-type: none"> • May be paid when submitted on a different bill type other than outpatient hospital (13x). • An alternate code that is payable when submitted on an outpatient hospital bill type (13x) may be available.
C	Inpatient procedures	<p>If covered by Iowa Medicaid as an outpatient hospital service, the service is not paid under OPPS APC, but is paid based on the Iowa Medicaid fee schedule for outpatient hospital services established pursuant to 79.1(1) "c."</p> <p>If not covered by Iowa Medicaid as an outpatient hospital service, the service is not paid under OPPS APC. Admit the patient and bill as inpatient care.</p>
D	Discontinued codes	Not paid under OPPS APC or any other Medicaid payment system.
E	<p>Items, codes, and services:</p> <ul style="list-style-type: none"> • That are not covered by Medicare based on statutory exclusion and may or may not be covered by Iowa Medicaid; or • That are not covered by Medicare for reasons other than statutory exclusion and may or may not be covered by Iowa Medicaid; or • That are not recognized by Medicare but for which an alternate code for the same item or service may be available under Iowa Medicaid; or • For which separate payment is not provided by Medicare but may be provided by Iowa Medicaid. 	<p>If covered by Iowa Medicaid, the item, code, or service is not paid under OPPS APC, but is paid based on the Iowa Medicaid fee schedule for outpatient hospital services established pursuant to 79.1(1) "c."</p> <p>If not covered by Iowa Medicaid, the item, code, or service is not paid under OPPS APC or any other Medicaid payment system.</p>
F	<p>Certified registered nurse anesthetist services</p> <p>Corneal tissue acquisition</p> <p>Hepatitis B vaccines</p>	<p>If covered by Iowa Medicaid, the item or service is not paid under OPPS APC, but is paid based on the Iowa Medicaid fee schedule for outpatient hospital services established pursuant to 79.1(1) "c."</p> <p>If not covered by Iowa Medicaid, the item or service is not paid under OPPS APC or any other Medicaid payment system.</p>

Indicator	Item, Code, or Service	OPPS Payment Status
G	Pass-through drugs and biologicals	<p>If covered by Iowa Medicaid, the item is not paid under OPPS APC, but is paid based on the Iowa Medicaid fee schedule for outpatient hospital services established pursuant to 79.1(1)“c.”</p> <p>If not covered by Iowa Medicaid, the item is not paid under OPPS APC or any other Medicaid payment system.</p>
H	Pass-through device categories	<p>If covered by Iowa Medicaid, the device is not paid under OPPS APC, but is paid based on the Iowa Medicaid fee schedule for outpatient hospital services established pursuant to 79.1(1)“c.”</p> <p>If not covered by Iowa Medicaid, the device is not paid under OPPS APC or any other Medicaid payment system.</p>
K	Non-pass-through drugs and biologicals Therapeutic radiopharmaceuticals	<p>If covered by Iowa Medicaid, the item is:</p> <ul style="list-style-type: none"> • Paid under OPPS APC with a separate APC payment when both an APC and an APC weight are established. • Paid based on the Iowa Medicaid fee schedule for outpatient hospital services established pursuant to 79.1(1)“c” when either no APC or APC weight is established. <p>If not covered by Iowa Medicaid, the item is not paid under OPPS APC or any other Medicaid payment system.</p>
L	Influenza vaccine Pneumococcal pneumonia vaccine	<p>If covered by Iowa Medicaid, the vaccine is not paid under OPPS APC, but is paid based on the Iowa Medicaid fee schedule for outpatient hospital services established pursuant to 79.1(1)“c.”</p> <p>If not covered by Iowa Medicaid, the vaccine is not paid under OPPS APC or any other Medicaid payment system.</p>
M	Items and services not billable to the Medicare fiscal intermediary	<p>If covered by Iowa Medicaid, the item or service is not paid under OPPS APC, but is paid based on the Iowa Medicaid fee schedule for outpatient hospital services established pursuant to 79.1(1)“c.”</p> <p>If not covered by Iowa Medicaid, the item or service is not paid under OPPS APC or any other Medicaid payment system.</p>
N	Packaged services not subject to separate payment under Medicare OPPS payment criteria	Paid under OPPS APC. Payment, including outliers, is included with payment for other services; therefore, no separate payment is made.
P	Partial hospitalization	Not a covered service under Iowa Medicaid.

Indicator	Item, Code, or Service	OPPS Payment Status
Q1	STVX-packaged codes	<p>Paid under OPPS APC.</p> <ul style="list-style-type: none"> • Packaged APC payment if billed on the same date of service as HCPCS code assigned status indicator “S,” “T,” “V,” or “X.” • In all other circumstances, payment is made through a separate APC payment.
Q2	T-packaged codes	<p>Paid under OPPS APC.</p> <ul style="list-style-type: none"> • Packaged APC payment if billed on the same date of service as HCPCS code assigned status indicator “T.” • In all other circumstances, payment is made through a separate APC payment.
Q3	Codes that may be paid through a composite APC	<p>If covered by Iowa Medicaid, the code is paid under OPPS APC with separate APC payment.</p> <p>If not covered by Iowa Medicaid, the code is not paid under OPPS APC or any other Medicaid payment system.</p>
R	Blood and blood products	<p>If covered by Iowa Medicaid, the item is paid under OPPS APC with separate APC payment.</p> <p>If not covered by Iowa Medicaid, the item is not paid under OPPS APC or any other Medicaid payment system.</p>
S	Significant procedure, not discounted when multiple	<p>If covered by Iowa Medicaid, the procedure is paid under OPPS APC with separate APC payment.</p> <p>If not covered by Iowa Medicaid, the procedure is not paid under OPPS APC or any other Medicaid payment system.</p>
T	Significant procedure, multiple reduction applies	<p>If covered by Iowa Medicaid, the procedure is paid under OPPS APC with separate APC payment subject to multiple reduction.</p> <p>If not covered by Iowa Medicaid, the procedure is not paid under OPPS APC or any other Medicaid payment system.</p>
U	Brachytherapy sources	<p>If covered by Iowa Medicaid, the procedure is paid under OPPS APC with separate APC payment.</p> <p>If not covered by Iowa Medicaid, the procedure is not paid under OPPS APC or any other Medicaid payment system.</p>
V	Clinic or emergency department visit	<p>If covered by Iowa Medicaid, the service is paid under OPPS APC with separate APC payment, subject to limits on nonemergency services provided in an emergency room pursuant to 79.1(16)“r.”</p> <p>If not covered by Iowa Medicaid, the service is not paid under OPPS APC or any other Medicaid payment system.</p>

Indicator	Item, Code, or Service	OPPS Payment Status
X	Ancillary services	<p>If covered by Iowa Medicaid, the service is paid under OPPS APC with separate APC payment.</p> <p>If not covered by Iowa Medicaid, the service is not paid under OPPS APC or any other Medicaid payment system.</p>
Y	Nonimplantable durable medical equipment	<p>For items covered by Iowa Medicaid as an outpatient hospital service, the item is not paid under OPPS APC, but is paid based on the Iowa Medicaid fee schedule for outpatient hospital services established pursuant to 79.1(1) "c."</p> <p>For items not covered by Iowa Medicaid as an outpatient hospital service, the item is not paid as an outpatient hospital service, but may be paid by Iowa Medicaid under the specific rate or methodology established by other rules (other than outpatient hospital).</p>

d. Calculation of case-mix indices. Hospital-specific and statewide case-mix indices shall be calculated using the Medicaid claim set.

(1) Hospital-specific case-mix indices are calculated by summing the relative weights for each APC service at that hospital and dividing the total by the number of APC services for that hospital.

(2) The statewide case-mix index is calculated by summing the relative weights for each APC service for all claims and dividing the total by the statewide total number of APC services. Claims for hospitals receiving reimbursement as critical access hospitals during any of the period included in the base-year cost report are not used in calculating the statewide case-mix index.

e. Calculation of the hospital-specific base APC rates.

(1) Using the hospital's base-year cost report, hospital-specific outpatient cost-to-charge ratios are calculated for each ancillary and outpatient cost center of the Medicare cost report, Form CMS 2552-96.

(2) The cost-to-charge ratios are applied to each line item charge reported on claims from the Medicaid claim set to calculate the Medicaid cost per service. The hospital's total outpatient Medicaid cost is the sum of the Medicaid cost per service for all line items.

(3) The following items are subtracted from the hospital's total outpatient Medicaid costs:

1. The total calculated Medicaid direct medical education cost for interns and residents based on the hospital's base-year cost report.

2. The total calculated Medicaid cost for services listed at 441—subrule 78.31(1), paragraphs "g" to "n."

3. The total calculated Medicaid cost for ambulance services.

4. The total calculated Medicaid cost for services paid based on the Iowa Medicaid fee schedule.

(4) The remaining amount is multiplied by a factor to limit aggregate expenditures to available funding, divided by the hospital-specific case-mix index, and then divided by the total number of APC services for that hospital from the Medicaid claim set.

(5) Hospital-specific base APC rates are not computed for hospitals receiving reimbursement as critical access hospitals during any of the period included in the base-year cost report.

f. Calculation of statewide base APC rate.

(1) The statewide average base APC rate is calculated by summing the outpatient Medicaid cost for all hospitals and subtracting the following:

1. The total calculated Medicaid direct medical education cost for interns and residents for all hospitals.

2. The total calculated Medicaid cost for services listed at 441—subrule 78.31(1), paragraphs "g" to "n," for all hospitals.

3. The total calculated Medicaid cost for ambulance services for all hospitals.

4. The total calculated Medicaid cost for services paid based on the Iowa Medicaid fee schedule for all hospitals.

(2) The resulting amount is multiplied by a factor to limit aggregate expenditures to available funding, divided by the statewide case-mix index, and then divided by the statewide total number of APC services from the Medicaid claim set.

(3) Data for hospitals receiving reimbursement as critical access hospitals during any of the period included in the base-year cost report is not used in calculating the statewide average base APC rate.

g. Cost outlier payment policy. Additional payment is made for services provided during a single visit that exceed the following Medicaid criteria of cost outliers for each APC. Outlier payments are determined on an APC-by-APC basis.

(1) An APC qualifies as a cost outlier when the cost of the service exceeds both the multiple threshold and the fixed-dollar threshold.

(2) The multiple threshold is met when the cost of furnishing an APC service exceeds 1.75 times the APC payment amount.

(3) The fixed-dollar threshold is met when the cost of furnishing an APC service exceeds the APC payment amount plus \$2,000.

(4) If both the multiple threshold and the fixed-dollar threshold are met, the outlier payment is calculated as 50 percent of the amount by which the hospital's cost of furnishing the APC service or procedure exceeds the multiple threshold.

(5) The cost of furnishing the APC service or procedure is calculated using a single overall hospital-specific cost-to-charge ratio determined from the base-year cost report. Costs appearing on a claim that are attributable to packaged APC services for which no separate payment is made are allocated to all nonpackaged APC services that appear on that claim. The amount allocated to each nonpackaged APC service is based on the proportion the APC payment rate for that APC service bears to the total APC rates for all nonpackaged APC services on the claim.

h. Payment to critical access hospitals. Initial, interim payments to critical access hospitals as defined in paragraph 79.1(5) "a" shall be the hospital's line-item charge multiplied by the hospital's Medicaid outpatient cost-to-charge ratio. These interim payments are subject to annual retrospective adjustment equal to the difference between the reasonable costs of covered services provided to eligible fee-for-service Medicaid members (excluding members in managed care) and the Medicaid reimbursement received. The department shall determine the reasonable costs of services based on the hospital's annual cost reports and Medicare cost principles. When the interim amounts paid exceed reasonable costs, the department shall recover the difference.

(1) After any retrospective adjustment, the department shall update the cost-to-charge ratio to reflect as accurately as is possible the reasonable costs of providing the covered service to eligible fee-for-service Medicaid members for the coming year. The department shall base these changes on the most recent utilization as submitted to the Iowa Medicaid enterprise provider cost audit and rate setting unit and Medicare cost principles.

(2) Once a hospital begins receiving reimbursement as a critical access hospital, the cost-to-charge ratio is not subject to rebasing as provided in paragraph 79.1(16) "j."

i. Cost-reporting requirements. Hospitals shall prepare annual cost reports in accordance with generally accepted accounting principles as defined by the American Institute of Certified Public Accountants and in accordance with Medicare Provider Reimbursement Manual, CMS Publication 15, subject to the exceptions and limitations provided in this rule.

(1) Using electronic media, each hospital shall submit the following:

1. The hospital's Medicare cost report (Form CMS 2552-96, Hospitals and Healthcare Complex Cost Report);

2. Either Form 470-4515, Critical Access Hospital Supplemental Cost Report, or Form 470-4514, Hospital Supplemental Cost Report; and

3. A copy of the revenue code crosswalk used to prepare the Medicare cost report.

(2) The cost reports and supporting documentation shall be sent to the Iowa Medicaid Enterprise, Provider Cost Audit and Rate Setting Unit, 100 Army Post Road, P.O. Box 36450, Des Moines, Iowa 50315.

(3) The cost reports shall be submitted on or before the last day of the fifth calendar month following the close of the period covered by the report. For fiscal periods ending on a day other than the last day of the month, cost reports are due 150 days after the last day of the cost-reporting period. Extensions of the due date for filing a cost report granted by the Medicare fiscal intermediary shall be accepted by Iowa Medicaid.

j. Rebasing.

(1) Effective January 1, 2009, and annually thereafter, the department shall update the OPPS APC relative weights using the most current calendar update as published by the Centers for Medicare and Medicaid Services.

(2) Effective January 1, 2009, and every three years thereafter, blended base APC rates shall be rebased. Cost reports used in rebasing shall be the hospital fiscal year-end Form CMS 2552-96, Hospital and Healthcare Complex Cost Report, as submitted to Medicare in accordance with Medicare cost report submission time lines for the hospital fiscal year ending during the preceding calendar year. If a hospital does not provide this cost report, including the Medicaid cost report and revenue code crosswalk, to the Iowa Medicaid enterprise provider cost audit and rate setting unit by May 31 of a year in which rebasing occurs, the most recent submitted cost report will be used.

(3) Effective January 1, 2009, and every three years thereafter, case-mix indices shall be recalculated using valid claims most nearly matching each hospital's fiscal year end.

(4) The graduate medical education and disproportionate share fund shall be updated as provided in subparagraph 79.1(16)"v"(3).

k. Payment to out-of-state hospitals. Out-of-state hospitals providing care to members of Iowa's Medicaid program shall be reimbursed in the same manner as Iowa hospitals, except as provided in subparagraphs (1) and (2).

(1) For out-of-state hospitals that submit a cost report no later than May 31 in the most recent rebasing year, APC payment amounts will be based on the blended base APC rate using hospital-specific, Iowa-only Medicaid data. For other out-of-state hospitals, APC payment amounts will be based on the Iowa statewide base APC rate.

(2) Out-of-state hospitals do not qualify for direct medical education payments pursuant to paragraph 79.1(16)"v."

l. Preadmission, preauthorization or inappropriate services. Inpatient or outpatient services that require preadmission or preprocedure approval by the quality improvement organization (QIO) are updated yearly and are available from the QIO.

(1) The hospital shall provide the QIO authorization number on the claim form to receive payment. Claims for services requiring preadmission or preprocedure approval that are submitted without this authorization number will be denied.

(2) To safeguard against other inappropriate practices, the department, through the QIO, will monitor admission practices and quality of care. If an abuse of the prospective payment system is identified, payments for abusive practices may be reduced or denied. In reducing or denying payment, Medicaid adopts the Medicare QIO regulations.

m. Health care access assessment inflation factor. Effective with the implementation of the health care access assessment paid pursuant to 441—Chapter 36, Division III, a health care access assessment inflation factor shall be applied to the Medicaid blended base APC rate as otherwise calculated pursuant to this subrule for all "participating hospitals" as defined in 441—subrule 36.10(1).

(1) Calculation of inflation factor. The health care access assessment inflation factor for participating hospitals shall be calculated by dividing the amount allowed under the Medicare outpatient upper payment limit for the fiscal year beginning July 1, 2010, by the sum of the projected expenditures for participating hospitals for the fiscal year beginning July 1, 2010, as determined by the fiscal management division of the department, and the amount allowed under the Medicare outpatient upper payment limit.

(2) **Implementation date.** The health care access assessment inflation factor shall not be implemented until federal financial participation to match money collected from the health care access assessment pursuant to 441—Chapter 36, Division III, has been approved by the federal Centers for Medicare and Medicaid Services.

(3) **End date.** Application of the health care access assessment inflation factor shall terminate if the health care access assessment is terminated pursuant to rule 441—36.12(83GA,SF2388). If federal match money is unavailable for a retroactive period or the authority to collect the assessment is rescinded for a retroactive period, the department shall:

1. Recalculate Medicaid rates in effect during that period without the application of the health care access assessment inflation factor;
2. Recompute Medicaid payments due based on the recalculated Medicaid rates;
3. Recoup any previous overpayments; and
4. Determine for each hospital the amount of health care access assessment collected during that period and refund that amount to the facility.

n. Determination of inpatient admission. A person is considered to be an inpatient when a formal inpatient admission occurs, when a physician intends to admit a person as an inpatient, or when a physician determines that a person being observed as an outpatient in an observation or holding bed should be admitted to the hospital as an inpatient. In cases involving outpatient observation status, the determinant of patient status is not the length of time the patient was being observed, rather whether the observation period was medically necessary to determine whether a patient should be admitted to the hospital as an inpatient. Outpatient observation lasting greater than a 24-hour period will be subject to review by the QIO to determine the medical necessity of each case. For those outpatient observation cases where medical necessity is not established, reimbursement shall be denied for the services found to be unnecessary for the provision of that care, such as the use of the observation room.

o. Inpatient admission after outpatient services. If a patient is admitted as an inpatient within three days of the day in which outpatient services were rendered, all outpatient services related to the principal diagnosis are considered inpatient services for billing purposes. The day of formal admission as an inpatient is considered as the first day of hospital inpatient services. **EXCEPTION:** This requirement does not apply to critical access hospitals.

p. Cost report adjustments. Rescinded IAB 6/11/03, effective 7/16/03.

q. Determination of payment amounts for mental health noninpatient (NIP) services. Mental health NIP services are limited as set forth at 441—subparagraph 78.31(4)“d”(7) and are reimbursed on a fee schedule basis. Mental health NIP services are the responsibility of the managed mental health care and substance abuse (Iowa Plan) contractor for persons eligible for managed mental health care.

r. Services delivered in the emergency room. Payment to a hospital for assessment of any Medicaid member in an emergency room shall be made pursuant to fee schedule. Payment for treatment of a Medicaid member in an emergency room shall be made as follows:

(1) If the emergency room visit results in an inpatient hospital admission, the treatment provided in the emergency room is paid for as part of the payment for the inpatient services provided.

(2) If the emergency room visit does not result in an inpatient hospital admission but involves emergency services as defined in paragraph 79.1(13)“k,” payment for treatment provided in the emergency room shall be made at the full APC payment for the treatment provided.

(3) If the emergency room visit does not result in an inpatient hospital admission and does not involve emergency services as defined in paragraph 79.1(13)“k,” payment for treatment provided in the emergency room depends on whether the member had a referral to the emergency room and on whether the member is participating in the MediPASS program.

1. For members not participating in the MediPASS program who were referred to the emergency room by appropriate medical personnel and for members participating in the MediPASS program who were referred to the emergency room by their MediPASS primary care physician, payment for treatment provided in the emergency room shall be made at 75 percent of the APC payment for the treatment provided.

2. For members not participating in the MediPASS program who were not referred to the emergency room by appropriate medical personnel, payment for treatment provided in the emergency room shall be made at 50 percent of the APC payment for the treatment provided.

3. For members participating in the MediPASS program who were not referred to the emergency room by their MediPASS primary care physician, no payment will be made for treatment provided in the emergency room.

s. Limit on payments. Payments under the ambulatory payment classification (APC) methodology, as well as other payments for outpatient services, are subject to upper limit rules set forth in 42 CFR 447.321 as amended to September 5, 2001, and 447.325 as amended to January 26, 1993. Requirements under these sections state that, in general, Medicaid may not make payments to providers that would exceed the amount that would be payable to providers under comparable circumstances under Medicare.

t. Government-owned facilities. Rescinded IAB 6/30/10, effective 7/1/10.

u. QIO review. The QIO will review a yearly random sample of hospital outpatient service cases performed for Medicaid members and identified on claims data from all Iowa and bordering state hospitals in accordance with the terms in the contract between the department and the QIO. The QIO contract is available for review at the Iowa Medicaid Enterprise Office, 100 Army Post Road, Des Moines, Iowa 50315.

v. Graduate medical education and disproportionate share fund. Payment shall be made to hospitals qualifying for direct medical education directly from the graduate medical education and disproportionate share fund. The requirements to receive payments from the fund, the amount allocated to the fund and the methodology used to determine the distribution amounts from the fund are as follows:

(1) Qualifying for direct medical education. Iowa hospitals qualify for direct medical education payments if direct medical education costs that qualify for payment as medical education costs under the Medicare program are contained in the hospital's base year cost report and in the most recent cost report submitted before the start of the state fiscal year for which payments are being made. Out-of-state hospitals do not qualify for direct medical education payments.

(2) Allocation to fund for direct medical education. The total annual state fiscal year funding that is allocated to the graduate medical education and disproportionate share fund for direct medical education related to outpatient services is \$2,766,718.25. If a hospital fails to qualify for direct medical education payments from the fund because the hospital does not report direct medical education costs that qualify for payment as medical education costs under the Medicare program in the most recent cost report submitted before the start of the state fiscal year for which payments are being made, the amount of money that would have been paid to that hospital shall be removed from the fund.

(3) Distribution to qualifying hospitals for direct medical education. Distribution of the amount in the fund for direct medical education shall be on a monthly basis. To determine the amount to be distributed to each qualifying hospital for direct medical education, the following formula is used:

1. Multiply the total count of outpatient visits for claims paid from the GME/DSH fund apportionment claim set for each hospital reporting direct medical education costs that qualify for payment as medical education costs under the Medicare program in the hospital's base year cost report by each hospital's direct medical education rate to obtain a dollar value.

2. Sum the dollar values for each hospital, then divide each hospital's dollar value by the total dollar value, resulting in a percentage.

3. Multiply each hospital's percentage by the amount allocated for direct medical education to determine the payment to each hospital.

w. Final settlement for state-owned teaching hospital.

(1) Effective July 1, 2010, total annual payments to an Iowa state-owned hospital for inpatient and outpatient hospital services shall equal 100 percent of allowable medical assistance program costs, not to exceed the sum of the following:

1. Payments for inpatient hospital services calculated in accordance with subrule 79.1(5), plus

2. Payment for outpatient hospital services calculated in accordance with subrule 79.1(16), plus

3. \$9,900,000.

(2) One-twelfth of the \$9,900,000 increase in reimbursement shall be distributed to the hospital on a monthly basis.

(3) The Iowa Medicaid enterprise shall complete a final settlement based on the hospital's Medicare cost report. If the aggregate payments are less than the hospital's actual medical assistance program costs, no additional payment shall be made.

(4) If the sum of the inpatient hospital service payments plus outpatient hospital service payments plus the \$9,900,000 exceeds 100 percent of allowable inpatient and outpatient costs, the department shall request and collect from the hospital the amount by which payments exceed actual medical assistance program costs.

79.1(17) *Reimbursement for home- and community-based services home and vehicle modification and equipment.* Payment is made for home and vehicle modifications, assistive devices, specialized medical equipment, and environmental modifications and adaptive devices at the amount authorized by the department through a quotation, contract, or invoice submitted by the provider.

a. The case manager shall submit the service plan and the contract, invoice or quotations from the providers to the Iowa Medicaid enterprise for prior approval before the modification is initiated or the equipment is purchased. Payment shall not be approved for duplicate items.

b. Whenever possible, three itemized bids for the modification or quotations for equipment purchase shall be presented for review. The amount payable shall be based on the least expensive item that meets the member's medical needs.

c. Payment for most items shall be based on a fee schedule and shall conform to the limitations set forth in subrule 79.1(12).

(1) For services and items that are furnished under Part B of Medicare, the fee shall be the lowest charge allowed under Medicare.

(2) For services and items that are furnished only under Medicaid, the fee shall be the lowest charge determined by the department according to the Medicare reimbursement method described in Section 1834(a) of the Social Security Act (42 U.S.C. 1395m), Payment for Durable Medical Equipment.

(3) Payment for supplies with no established Medicare fee shall be at the average wholesale price for the item less 10 percent.

(4) Payment for items with no Medicare fee, Medicaid fee, or average wholesale price shall be made at the manufacturer's suggested retail price less 15 percent.

(5) Payment for items with no Medicare fee, Medicaid fee, average wholesale price, or manufacturer's suggested retail price shall be made at the dealer's cost plus 10 percent. The actual invoice for the item from the manufacturer must be submitted with the claim. Catalog pages or printouts supplied by the provider are not considered invoices.

(6) For selected medical services, supplies, and equipment, including equipment servicing, that generally do not vary significantly in quality from one provider to another, the payment shall be the lowest price for which such devices are widely and consistently available in a locality.

(7) Payment for used equipment shall not exceed 80 percent of the purchase allowance.

(8) No allowance shall be made for delivery, freight, postage, or other provider operating expenses for durable medical equipment, prosthetic devices, or sickroom supplies.

79.1(18) *Pharmaceutical case management services reimbursement.* Pharmacist and physician pharmaceutical case management (PCM) team members shall be equally reimbursed for participation in each of the four services described in rule 441—78.47(249A). The following table contains the amount each team member shall be reimbursed for the services provided and the maximum number of payments for each type of assessment. Payment for services beyond the maximum number of payments shall be considered on an individual basis after peer review of submitted documentation of medical necessity.

<u>Service</u>	<u>Payment amount</u>	<u>Number of payments</u>
Initial assessment	\$75	One per patient
New problem assessment	\$40	Two per patient per 12 months
Problem follow-up assessment	\$40	Four per patient per 12 months
Preventative follow-up assessment	\$25	One per patient per 6 months

79.1(19) *Reimbursement for translation and interpretation services.* Reimbursement for translation and interpretation services shall be made to providers based on the reimbursement methodology for the provider category as defined in subrule 79.1(2).

a. For those providers whose basis of reimbursement is cost-related, translation and interpretation services shall be considered an allowable cost.

b. For those providers whose basis of reimbursement is a fee schedule, a fee shall be established for translation and interpretation services, which shall be treated as a reimbursable service. In order for translation or interpretation to be covered, it must be provided by separate employees or contractors solely performing translation or interpretation activities.

79.1(20) *Dentists.* The dental fee schedule is based on the definitions of dental and surgical procedures given in the Current Dental Terminology, Third Edition (CDT-3).

79.1(21) *Rehabilitation agencies.* Subject to the Medicaid upper limit in 79.1(2), payments to rehabilitation agencies shall be made as provided in the areawide fee schedule established for Medicare by the Centers for Medicare and Medicaid Services (CMS). The Medicare fee schedule is based on the definitions of procedures from the physicians' Current Procedural Terminology (CPT) published by the American Medical Association. CMS adjusts the fee schedules annually to reflect changes in the consumer price index for all urban customers.

79.1(22) *Medicare crossover claims for inpatient and outpatient hospital services.* Subject to approval of a state plan amendment by the federal Centers for Medicare and Medicaid Services, payment for crossover claims shall be made as follows.

a. Definitions. For purposes of this subrule:

"Crossover claim" means a claim for Medicaid payment for Medicare-covered inpatient or outpatient hospital services rendered to a Medicare beneficiary who is also eligible for Medicaid. Crossover claims include claims for services rendered to beneficiaries who are eligible for Medicaid in any category, including, but not limited to, qualified Medicare beneficiaries and beneficiaries who are eligible for full Medicaid coverage.

"Medicaid-allowed amount" means the Medicaid prospective reimbursement for the services rendered (including any portion to be paid by the Medicaid beneficiary as copayment or spenddown), as determined under state and federal law and policies.

"Medicaid reimbursement" means any amount to be paid by the Medicaid beneficiary as a Medicaid copayment or spenddown and any amount to be paid by the department after application of any applicable Medicaid copayment or spenddown.

"Medicare payment amount" means the Medicare reimbursement rate for the services rendered in a crossover claim, excluding any Medicare coinsurance or deductible amounts to be paid by the Medicare beneficiary.

b. Reimbursement of crossover claims. Crossover claims for inpatient or outpatient hospital services covered under Medicare and Medicaid shall be reimbursed as follows.

(1) If the Medicare payment amount for a crossover claim exceeds or equals the Medicaid-allowed amount for that claim, Medicaid reimbursement for the crossover claim shall be zero.

(2) If the Medicaid-allowed amount for a crossover claim exceeds the Medicare payment amount for that claim, Medicaid reimbursement for the crossover claim shall be the lesser of:

1. The Medicaid-allowed amount minus the Medicare payment amount; or
2. The Medicare coinsurance and deductible amounts applicable to the claim.

79.1(23) *Reimbursement for remedial services.* Reimbursement for remedial services provided before July 1, 2011, shall be made on the basis of a unit rate that is calculated retrospectively for each

provider, considering reasonable and proper costs of operation. The unit rate shall not exceed the established unit-of-service limit on reasonable costs pursuant to subparagraph 79.1(23)“c”(1). The unit of service may be a quarter hour, a half hour, an hour, a half day, or a day, depending on the service provided.

a. Interim rate. Providers shall be reimbursed through a prospective interim rate equal to the previous year’s retrospectively calculated unit-of-service rate. On an interim basis, pending determination of remedial services provider costs, the provider may bill for and shall be reimbursed at a unit-of-service rate that the provider and the Iowa Medicaid enterprise may reasonably expect to produce total payments to the provider for the provider’s fiscal year that are consistent with Medicaid’s obligation to reimburse that provider’s reasonable costs. The interim unit-of-service rate is subject to the established unit-of-service limit on reasonable costs pursuant to subparagraph 79.1(23)“c”(1).

b. Cost reports. Reasonable and proper costs of operation shall be determined based on cost reports submitted by the provider.

(1) Financial information shall be based on the provider’s financial records. When the records are not kept on an accrual basis of accounting, the provider shall make the adjustments necessary to convert the information to an accrual basis for reporting. Failure to maintain records to support the cost report may result in termination of the provider’s Medicaid enrollment.

(2) The provider shall complete Form 470-4414, Financial and Statistical Report for Remedial Services, and submit it to the IME Provider Cost Audit and Rate Setting Unit, P.O. Box 36450, Des Moines, Iowa 50315, within three months of the end of the provider’s fiscal year.

(3) A provider may obtain a 30-day extension for submitting the cost report by sending a letter to the IME provider cost audit and rate setting unit before the cost report due date. No extensions will be granted beyond 30 days.

(4) Providers of services under multiple programs shall submit a cost allocation schedule, prepared in accordance with the generally accepted accounting principles and requirements specified in OMB Circular A-87. Costs reported under remedial services shall not be reported as reimbursable costs under any other funding source. Costs incurred for other services shall not be reported as reimbursable costs under remedial services.

c. Rate determination. Cost reports as filed shall be subject to review and audit by the Iowa Medicaid enterprise to determine the actual cost of services rendered to Medicaid members, using an accepted method of cost apportionment (as specified in OMB Circular A-87).

(1) A reasonable cost for a member is one that does not exceed 110 percent of the average allowable costs reported by Iowa Medicaid providers for providing similar remedial services to members who have similar diagnoses and live in similar settings, less 5 percent.

(2) When the reasonable and proper costs of operation are determined, a retroactive adjustment shall be made. The retroactive adjustment represents the difference between the amount received by the provider through an interim rate during the year for covered services and the reasonable and proper costs of operation determined in accordance with this subrule.

79.1(24) Reimbursement for home- and community-based habilitation services. Reimbursement for case management, job development, and employer development services provided prior to July 1, 2013, is based on a fee schedule developed using the methodology described in paragraph 79.1(1)“d.” Reimbursement for home-based habilitation, day habilitation, prevocational habilitation, enhanced job search and supports to maintain employment services provided prior to July 1, 2013, is based on a retrospective cost-related rate calculated using the methodology in paragraphs 79.1(24)“b” and “c.” Reimbursement for all home- and community-based habilitation services provided on or after July 1, 2013, shall be as provided in paragraph 79.1(24)“d.” All rates are subject to the upper limits established in subrule 79.1(2).

a. Units of service.

(1) A unit of case management is 15 minutes.

(2) A unit of home-based habilitation is a 15-minute unit (for up to 31 units per day) or one day (for 8 or more hours per day), based on the average hours of service provided during a 24-hour period

as an average over a calendar month. Reimbursement for services shall not exceed the upper limit for daily home-based habilitation services set in 79.1(2).

1. The daily unit of service shall be used when a member receives services for 8 or more hours provided during a 24-hour period as an average over a calendar month. The 15-minute unit shall be used when the member receives services for 1 to 31 15-minute units provided during a 24-hour period as an average over a calendar month.

2. The member's comprehensive service plan must identify and reflect the need for the amount of supervision and skills training requested. The provider's documentation must support the number of direct support hours identified in the comprehensive service plan.

(3) A unit of day habilitation is 15 minutes (up to 16 units per day) or a full day (4.25 to 8 hours).

(4) A unit of prevocational habilitation is an hour (for up to 4 units per day) or a full day (4.25 to 8 hours).

(5) A unit of supported employment habilitation for activities to obtain a job is:

1. One job placement for job development and employer development.

2. A 15-minute unit for enhanced job search.

(6) A unit of supported employment habilitation supports to maintain employment is a 15-minute unit.

b. Submission of cost reports. For services provided prior to July 1, 2013, the department shall determine reasonable and proper costs of operation for home-based habilitation, day habilitation, prevocational habilitation, and supported employment based on cost reports submitted by the provider on Form 470-4425, Financial and Statistical Report for HCBS Habilitation Services.

(1) Financial information shall be based on the provider's financial records. When the records are not kept on an accrual basis of accounting, the provider shall make the adjustments necessary to convert the information to an accrual basis for reporting. Failure to maintain records to support the cost report may result in termination of the provider's Medicaid enrollment.

(2) For home-based habilitation, the provider's cost report shall reflect all staff-to-member ratios and costs associated with members' specific support needs for travel and transportation, consulting, and instruction, as determined necessary by the interdisciplinary team for each consumer. The specific support needs must be identified in the member's comprehensive service plan. The total costs shall not exceed \$1570 per consumer per year. The provider must maintain records to support all expenditures.

(3) The provider shall submit the complete cost report to the IME Provider Cost Audit and Rate Setting Unit, P.O. Box 36450, Des Moines, Iowa 50315, within three months of the end of the provider's fiscal year. The submission must include a working trial balance. Cost reports submitted without a working trial balance will be considered incomplete.

(4) A provider may obtain a 30-day extension for submitting the cost report by sending a letter to the IME provider cost audit and rate setting unit before the cost report due date. No extensions will be granted beyond 30 days.

(5) A provider of services under multiple programs shall submit a cost allocation schedule, prepared in accordance with the generally accepted accounting principles and requirements specified in OMB Circular A-87. Costs reported under habilitation services shall not be reported as reimbursable costs under any other funding source. Costs incurred for other services shall not be reported as reimbursable costs under habilitation services.

(6) If a provider fails to submit a cost report for services provided through June 30, 2013, that meets the requirements of this paragraph, the Iowa Medicaid enterprise or the Iowa Plan for Behavioral Health contractor shall reduce the provider's rate to 76 percent of the current rate. The reduced rate shall be paid until the provider's cost report has been received by the Iowa Medicaid enterprise's provider cost audit and rate setting unit pursuant to subparagraph 79.1(24)"b"(4) but for not longer than three months, after which time no further payments will be made.

(7) A projected cost report shall be submitted when a new habilitation services provider enters the program or an existing habilitation services provider adds a new service code. A prospective interim rate shall be established using the projected cost report. The effective date of the rate shall be the day the provider becomes certified as a Medicaid provider or the day the new service is added.

c. Rate determination based on cost reports. For services provided prior to July 1, 2013, reimbursement shall be made using a unit rate that is calculated retrospectively for each provider, considering reasonable and proper costs of operation.

(1) Interim rates. Providers shall be reimbursed through a prospective interim rate equal to the previous year's retrospectively calculated unit-of-service rate. Pending determination of habilitation services provider costs, the provider may bill for and shall be reimbursed at a unit-of-service rate that the provider and the Iowa Medicaid enterprise may reasonably expect to produce total payments to the provider for the provider's fiscal year that are consistent with Medicaid's obligation to reimburse that provider's reasonable costs.

(2) Audit of cost reports. Cost reports as filed shall be subject to review and audit by the Iowa Medicaid enterprise to determine the actual cost of services rendered to Medicaid members, using an accepted method of cost apportionment (as specified in OMB Circular A-87).

(3) Retroactive adjustment. When the reasonable and proper costs of operation are determined, a retroactive adjustment shall be made. The retroactive adjustment represents the difference between the amount that the provider received during the year for covered services through an interim rate and the reasonable and proper costs of operation determined in accordance with this subrule.

d. Reimbursement for services provided on or after July 1, 2013.

(1) For dates of services July 1, 2013, through December 31, 2013, providers shall be reimbursed by the Iowa Plan for Behavioral Health contractor at the fee schedule or interim rate for the service and the provider in effect on June 30, 2013, with no retrospective adjustment or cost settlement. However, if a provider fails to submit a cost report for services provided prior to July 1, 2013, that meets the requirements of paragraph 79.1(24) "b," the Iowa Plan for Behavioral Health contractor shall reduce the provider's reimbursement rate to 76 percent of the rate in effect on June 30, 2013. The reduced rate shall be paid until acceptable cost reports for all services provided prior to July 1, 2013, have been received.

(2) For dates of services on or after January 1, 2014, providers shall be reimbursed by the Iowa Plan for Behavioral Health contractor at the rate negotiated by the provider and the contractor. However, if a provider fails to submit a cost report for services provided prior to July 1, 2013, that meets the requirements of paragraph 79.1(24) "b," the Iowa Plan for Behavioral Health contractor shall reduce the provider's reimbursement rate to 76 percent of the negotiated rate. The reduced rate shall be paid until acceptable cost reports for all services provided prior to July 1, 2013, have been received.

79.1(25) *Reimbursement for community mental health centers (CMHCs) and providers of mental health services to county residents pursuant to a waiver approved under Iowa Code section 225C.7(3).*

a. Reimbursement methodology for providers of mental health services to county residents pursuant to a waiver approved under Iowa Code section 225C.7(3). Effective for services rendered on or after October 1, 2006, providers of mental health services to county residents pursuant to a waiver approved under Iowa Code section 225C.7(3) that provide clinic services are paid on a reasonable-cost basis as determined by Medicare reimbursement principles.

b. Reimbursement methodology for community mental health centers. Effective for services rendered on or after July 1, 2014, community mental health centers may elect to be paid on either a 100 percent of reasonable costs basis, as determined by Medicare reimbursement principles, or in accordance with an alternative reimbursement rate methodology established by the Medicaid program's managed care contractor for mental health services and approved by the department of human services. Once a community mental health center chooses the alternative reimbursement rate methodology established by the Medicaid program's managed care contractor for mental health services, the community mental health center may not change its elected reimbursement methodology to 100 percent of reasonable costs.

c. Cost-based reimbursement. For providers of mental health services to county residents pursuant to a waiver approved under Iowa Code section 225C.7(3) and CMHCs that elect the 100 percent of reasonable costs basis of reimbursement, rates are initially paid on an interim basis and then are adjusted retroactively based on submission of a financial and statistical report, pursuant to the following.

(1) Until a provider that was enrolled in the Medicaid program before October 1, 2006, submits a cost report in order to develop a provider-specific interim rate, the Iowa Medicaid enterprise shall make interim payments to the provider based upon 105 percent of the greater of:

1. The statewide fee schedule for community mental health centers effective July 1, 2006, or
2. The average Medicaid managed care contracted fee amounts for community mental health centers effective July 1, 2006.

(2) For a provider that enrolls in the Medicaid program on or after October 1, 2006, until a provider-specific interim rate is developed, the Iowa Medicaid enterprise shall make interim payments based upon the average statewide interim rates for community mental health centers at the time services are rendered. A new provider may submit a projected cost report that the Iowa Medicaid enterprise will use to develop a provider-specific interim rate.

(3) Cost reports as filed are subject to review and audit by the Iowa Medicaid enterprise. The Iowa Medicaid enterprise shall determine each provider's actual, allowable costs in accordance with generally accepted accounting principles and in accordance with Medicare cost principles, subject to the exceptions and limitations in the department's administrative rules.

(4) The Iowa Medicaid enterprise shall make retroactive adjustment of the interim rate after the submission of annual cost reports. The adjustment represents the difference between the amount the provider received during the year through interim payments for covered services and the amount determined to be the actual, allowable cost of service rendered to Medicaid members.

(5) The Iowa Medicaid enterprise shall use each annual cost report to develop a provider-specific interim fee schedule to be paid prospectively. The effective date of the fee schedule change is the first day of the month following completion of the cost settlement.

d. Reporting requirements. All providers other than CMHCs that have elected the alternative reimbursement rate methodology established by the Medicaid program's managed care contractor for mental health services shall submit cost reports using Form 470-4419, Financial and Statistical Report. Hospital-based providers required to submit a cost report shall also submit the Medicare cost report, CMS Form 2552-96. The following requirements apply to all required cost reports.

(1) Financial information shall be based on the provider's financial records. When the records are not kept on an accrual basis of accounting, the provider shall make the adjustments necessary to convert the information to an accrual basis for reporting. Failure to maintain records to support the cost report may result in termination of the provider's enrollment with the Iowa Medicaid program.

(2) Providers that offer multiple programs shall submit a cost allocation schedule prepared in accordance with generally accepted accounting principles and requirements as specified in OMB Circular A-87 adopted in federal regulations at 2 CFR Part 225 as amended to August 31, 2005.

(3) Costs reported for community mental health clinic services shall not be reported as reimbursable costs under any other funding source. Costs incurred for other services shall not be reported as reimbursable costs under community mental health clinic services.

(4) Providers shall submit completed cost reports to the IME Provider Cost Audit and Rate Setting Unit, P.O. Box 36450, Des Moines, Iowa 50315. A provider that is not hospital-based shall submit Form 470-4419 on or before the last day of the third month after the end of the provider's fiscal year. A hospital-based provider shall submit both Form 470-4419 and CMS Form 2552-96 on or before the last day of the fifth month after the end of the provider's fiscal year.

(5) A provider may obtain a 30-day extension for submitting the cost report by submitting a letter to the IME provider cost audit and rate setting unit before the cost report due date. No extensions will be granted beyond 30 days.

(6) If a provider fails to submit a cost report that meets the requirements of this paragraph, the Iowa Medicaid enterprise shall reduce the provider's interim payments to 76 percent of the current interim rate. The reduced interim rate shall be paid for not longer than three months, after which time no further payments will be made.

79.1(26) Home health services.

a. Services included under the home health services program are reimbursed on the low utilization payment amount (LUPA) methodology, with state geographic adjustments.

b. Medicare LUPA per-visit rates in effect on July 1, 2013, are the basis for establishing the LUPA methodology for the initial reimbursement schedule.

c. Medicare LUPA per-visit rates shall be increased July 1 every two years to reflect the most recent Medicare LUPA rates.

d. Home health services subject to this methodology are skilled nursing, home health aide, physical therapy, occupational therapy, speech therapy, and medical social services provided by Medicare-certified home health agencies.

79.1(27) *Reimbursement for early periodic screening, diagnosis, and treatment private duty nursing and personal cares program.*

a. *Rate determination based on cost reports.* Reimbursement shall be made using an hourly rate that is calculated retrospectively for each provider, considering reasonable and proper costs of operation not to exceed the upper limit as provided in subrule 79.1(2).

(1) Interim rates. Providers shall be reimbursed through a prospective interim rate equal to the previous year's retrospectively calculated 15-minute and hourly rate. Pending determination of private duty nursing and personal cares program costs, the provider may bill for and shall be reimbursed at an hourly rate that the provider and the Iowa Medicaid enterprise (IME) may reasonably expect to produce total payments to the provider for the provider's fiscal year that are consistent with Medicaid's obligation to reimburse that provider's reasonable costs.

(2) Audit of cost reports. Cost reports as filed shall be subject to review or audit or both by the Iowa Medicaid enterprise to determine the actual cost of services in accordance with generally accepted accounting principles, Medicare cost principles published in Centers for Medicare and Medicaid Services Publication §15-1, and the Office of Management and Budget Circular A-87, Attachment B, subject to the exceptions and limitations in the department's administrative rules.

(3) Retroactive adjustment. When the reasonable and proper costs of operation are determined, a retroactive adjustment shall be made. The retroactive adjustment represents the difference between the amount that the provider received during the year for covered services through interim rates and the reasonable and proper costs of operation determined in accordance with this subrule.

b. *Financial and statistical report submission and reporting requirements.*

(1) The provider shall submit the complete Financial and Statistical Report, Form 1728-94, in an electronic format approved by the department to the IME provider cost audit and rate setting unit within five months of the end of the provider's fiscal year.

(2) The submission of the financial and statistical report must include a working trial balance that corresponds to the data contained on the financial and statistical report and the Medicare cost report. Financial and statistical reports submitted without a working trial balance and the Medicare cost report will be considered incomplete.

(3) A provider may obtain a 30-day extension for submitting the financial and statistical report by sending a letter to the IME provider cost audit and rate setting unit. The extension request must be received by the IME provider cost audit and rate setting unit before the original due date. No extensions will be granted beyond 30 days.

(4) Providers shall submit a completed financial and statistical report to the IME provider cost audit and rate setting unit in an electronic format that can be opened using the extension .xls or .xlsx. The supplemental documentation shall be submitted in a generally accepted business format. The report and required supplemental information shall be e-mailed to costaudit@dhs.state.ia.us on or before the last day of the fifth month after the end of the provider's fiscal year. One signed copy of the certification page of the Medicaid and Medicare cost reports shall be mailed to the IME Provider Cost Audit and Rate Setting Unit, P.O. Box 36450, Des Moines, Iowa 50315, no later than the due date of the required electronic submissions.

(5) If a provider fails to submit a cost report that meets the requirement of subparagraph 79.1(27) "b"(4), the department shall reduce payment to 75 percent of the current rate(s).

1. The reduced rate(s) shall be effective the first day of the sixth month following the provider's fiscal year end and shall remain in effect until the first day of the month after the delinquent report is received by the IME provider cost audit and rate setting unit.

2. The reduced rate(s) shall be paid for no longer than three months, after which time no further payments will be made until the first day of the month after the delinquent report is received by the IME provider cost audit and rate setting unit.

(6) Financial information shall be based on the provider's financial records. When the records are not kept on an accrual basis of accounting, the provider shall make the adjustments necessary to convert the information to an accrual basis for reporting and provide documentation detailing these adjustments. Failure to maintain records to support the cost report may result in the following, but not limited to:

1. Recoupment of Medicaid payments.
2. Penalties.
3. Sanctions pursuant to rule 441—79.3(249A).

(7) The department, in its sole discretion, may on its own initiative reopen a review of a financial and statistical report at any time. No other entity or person has the right to request that the department or its contractor reopen a review of a financial and statistical report, or to submit an amended financial and statistical report for review by the department, after the provider is notified of its reimbursement rates following review of a financial and statistical report.

(8) A projected cost report shall be submitted when a home health agency enters the program or adds private duty nursing and the personal cares program. Prospective interim rates shall be established using the projected cost report. The effective date of the rate shall be the day the provider becomes certified as a Medicaid provider or the day the new program is added.

(9) A provider of services under multiple programs shall submit a cost allocation schedule that was used during the preparation of the financial and statistical report.

(10) Costs reported under private duty nursing and the personal cares program shall not be reported as reimbursable costs under any other funding source. Costs incurred for other services shall not be reported as reimbursable costs under private duty nursing and the personal cares program.

(11) When a provider continues to include as an item of cost an item or items which had in a prior period been removed by an adjustment by the department or its contractor, in the total program costs, the contractor shall recommend to the department that the reimbursement rates be reduced to 75 percent of the current reimbursement rate for the entire quarter beginning the first day of the sixth month after the provider's fiscal year end. The department may, after considering the seriousness of the exception, make the reduction.

(12) Nothing in this subrule relieves a provider of its obligation to immediately inform the department that it has retained Medicaid funds to which it is not entitled as a result of any cost report process. A provider must notify the Iowa Medicaid enterprise when the provider notes that funds are incorrectly paid or when an overpayment has been detected.

c. Terminated home health agencies.

(1) A participating home health agency contemplating termination of private duty nursing and the personal cares program shall provide the department of human services with at least 60 days' prior notice. The person responsible for the termination is responsible for submission of a final financial and statistical report through the date of the termination. The final home health cost report shall meet the reporting requirements in paragraph 79.1(27) "b."

(2) For facilities that terminate activity with the Iowa Medicaid enterprise, a financial and statistical report from the beginning of the fiscal year to the date of termination will be required, regardless if termination is voluntary, involuntary or due to a change in ownership. All documentation in paragraph 79.1(27) "a" shall be submitted 45 days after the date of termination, by the terminated (closed) entity.

If no report is received within 45 days, the Iowa Medicaid enterprise will begin the process to recoup all funds for dates of service beginning from the last filed cost report to the date of termination.

This rule is intended to implement Iowa Code section 249A.4.

[**ARC 7835B**, IAB 6/3/09, effective 7/8/09; **ARC 7937B**, IAB 7/1/09, effective 7/1/09; **ARC 7957B**, IAB 7/15/09, effective 7/1/09 (See Delay note at end of chapter); **ARC 8205B**, IAB 10/7/09, effective 11/11/09; **ARC 8206B**, IAB 10/7/09, effective 11/11/09; **ARC 8344B**, IAB 12/2/09, effective 12/1/09; **ARC 8643B**, IAB 4/7/10, effective 3/11/10; **ARC 8647B**, IAB 4/7/10, effective 3/11/10; **ARC 8649B**, IAB 4/7/10, effective 3/11/10; **ARC 8894B**, IAB 6/30/10, effective 7/1/10; **ARC 8899B**, IAB 6/30/10, effective 7/1/10; **ARC 9046B**, IAB 9/8/10, effective 8/12/10; **ARC 9127B**, IAB 10/6/10, effective 11/10/10; **ARC 9134B**, IAB 10/6/10, effective 10/1/10; **ARC 9132B**, IAB 10/6/10, effective 11/1/10; **ARC 9176B**, IAB 11/3/10, effective 12/8/10; **ARC 9316B**, IAB 12/29/10, effective 2/2/11; **ARC 9403B**, IAB 3/9/11, effective 5/1/11; **ARC 9440B**, IAB 4/6/11, effective 4/1/11; **ARC 9487B**, IAB 5/4/11, effective 7/1/11; **ARC 9588B**, IAB 6/29/11, effective 9/1/11; **ARC 9706B**, IAB 9/7/11, effective 8/17/11; **ARC 9708B**, IAB 9/7/11, effective 8/17/11; **ARC 9710B**, IAB 9/7/11, effective 8/17/11; **ARC 9704B**, IAB 9/7/11, effective 9/1/11; **ARC 9712B**, IAB 9/7/11, effective 9/1/11; **ARC 9714B**, IAB 9/7/11, effective 9/1/11; **ARC 9719B**, IAB 9/7/11, effective 9/1/11; **ARC 9722B**, IAB 9/7/11, effective 9/1/11; **ARC 9884B**, IAB 11/30/11, effective 1/4/12; **ARC 9886B**, IAB 11/30/11, effective 1/4/12; **ARC 9887B**, IAB 11/30/11, effective 1/4/12; **ARC 9958B**, IAB 1/11/12, effective 2/15/12; **ARC 9959B**, IAB 1/11/12, effective 2/15/12; **ARC 9960B**, IAB 1/11/12, effective 2/15/12; **ARC 9966B**, IAB 2/8/12, effective 1/19/12; **ARC 0028C**, IAB 3/7/12, effective 4/11/12; **ARC 0029C**, IAB 3/7/12, effective 4/11/12; **ARC 9959B** nullified (See nullification note at end of chapter); **ARC 0191C**, IAB 7/11/12, effective 7/1/12; **ARC 0194C**, IAB 7/11/12, effective 7/1/12; **ARC 0196C**, IAB 7/11/12, effective 7/1/12; **ARC 0198C**, IAB 7/11/12, effective 7/1/12; **ARC 0358C**, IAB 10/3/12, effective 11/7/12; **ARC 0359C**, IAB 10/3/12, effective 12/1/12; **ARC 0355C**, IAB 10/3/12, effective 12/1/12; **ARC 0354C**, IAB 10/3/12, effective 12/1/12; **ARC 0360C**, IAB 10/3/12, effective 12/1/12; **ARC 0485C**, IAB 12/12/12, effective 2/1/13; **ARC 0545C**, IAB 1/9/13, effective 3/1/13; **ARC 0548C**, IAB 1/9/13, effective 1/1/13; **ARC 0581C**, IAB 2/6/13, effective 4/1/13; **ARC 0585C**, IAB 2/6/13, effective 1/9/13; **ARC 0665C**, IAB 4/3/13, effective 6/1/13; **ARC 0708C**, IAB 5/1/13, effective 7/1/13; **ARC 0710C**, IAB 5/1/13, effective 7/1/13; **ARC 0713C**, IAB 5/1/13, effective 7/1/13; **ARC 0757C**, IAB 5/29/13, effective 8/1/13; **ARC 0823C**, IAB 7/10/13, effective 9/1/13; **ARC 0838C**, IAB 7/24/13, effective 7/1/13; **ARC 0840C**, IAB 7/24/13, effective 7/1/13; **ARC 0842C**, IAB 7/24/13, effective 7/1/13; **ARC 0848C**, IAB 7/24/13, effective 7/1/13; **ARC 0864C**, IAB 7/24/13, effective 7/1/13; **ARC 0994C**, IAB 9/4/13, effective 11/1/13; **ARC 1051C**, IAB 10/2/13, effective 11/6/13; **ARC 1056C**, IAB 10/2/13, effective 11/6/13; **ARC 1057C**, IAB 10/2/13, effective 11/6/13; **ARC 1058C**, IAB 10/2/13, effective 11/6/13; **ARC 1071C**, IAB 10/2/13, effective 10/1/13; **ARC 1150C**, IAB 10/30/13, effective 1/1/14; **ARC 1152C**, IAB 10/30/13, effective 1/1/14; **ARC 1154C**, IAB 10/30/13, effective 1/1/14; **ARC 1481C**, IAB 6/11/14, effective 8/1/14; **ARC 1519C**, IAB 7/9/14, effective 7/1/14; **ARC 1521C**, IAB 7/9/14, effective 7/1/14; **ARC 1610C**, IAB 9/3/14, effective 8/13/14; **ARC 1608C**, IAB 9/3/14, effective 10/8/14; **ARC 1609C**, IAB 9/3/14, effective 10/8/14; **ARC 1699C**, IAB 10/29/14, effective 1/1/15; **ARC 1697C**, IAB 10/29/14, effective 1/1/15]

441—79.2(249A) Sanctions.

79.2(1) Definitions.

“Affiliates” means persons having an overt or covert relationship such that any one of them directly or indirectly controls or influences or has the power to control or influence another.

“Iowa Medicaid enterprise” means the entity comprised of department staff and contractors responsible for the management and reimbursement of Medicaid services for the benefit of Medicaid members.

“Person” means any individual human being or any company, firm, association, corporation, institution, or other legal entity. “Person” includes but is not limited to a provider and any affiliate of a provider.

“Probation” means a specified period of conditional participation in the medical assistance program.

“Provider” means an individual human being, firm, corporation, association, institution, or other legal entity, which is providing or has been approved to provide medical assistance to a member pursuant to the state medical assistance program.

“Suspension from participation” means an exclusion from participation for a specified period of time.

“Suspension of payments” means the temporary cessation of payments due a person until the resolution of a matter in dispute between a person and the department.

“Termination from participation” means a permanent exclusion from participation in the medical assistance program.

“Withholding of payments” means a reduction or adjustment of the amounts paid to a person on pending and subsequently submitted bills for purposes of offsetting payments made to, received by, or in the possession of a person.

79.2(2) Grounds for sanctions. The department may impose sanctions against any person when appropriate. Appropriate grounds for the department to impose sanctions include, but are not limited to, the following:

a. Presenting or causing to be presented for payment any false, intentionally misleading, or fraudulent claim for services or merchandise.

b. Submitting or causing to be submitted false, intentionally misleading, or fraudulent information for the purpose of obtaining greater compensation than that to which the person is legally entitled, including charges in excess of usual and customary charges.

c. Submitting or causing to be submitted false, intentionally misleading, or fraudulent information for the purpose of meeting prior authorization or level of care requirements.

d. Upon lawful demand, failing to disclose or make available to the department, the department's authorized agent, any law enforcement or peace officer, any agent of the department of inspections and appeals' Medicaid fraud control unit, any agent of the auditor of state, the Iowa department of justice, any false claims investigator as defined under Iowa Code chapter 685, or any other duly authorized federal or state agent or agency records of services provided to medical assistance members or records of payments made for those services.

e. Failing to provide or maintain quality services, or a requisite assurance of a framework of quality services to medical assistance recipients within accepted medical community standards as adjudged by professional peers if applicable. For purposes of this subrule, "quality services" means services provided in accordance with the applicable rules and regulations governing the services.

f. Engaging in a course of conduct or performing an act which is in violation of any federal, state, or local statute, rule, regulation, or ordinance, or an applicable contractual provision, that relates to, or arises out of, any publicly or privately funded health care program, including but not limited to any state medical assistance program.

g. Submitting a false, intentionally misleading, or fraudulent certification or statement, whether the certification or statement is explicit or implied, to the department or the department's representative or to any other publicly or privately funded health care program.

h. Overutilization of the medical assistance program by inducing, furnishing or otherwise causing a member to receive services or merchandise not required or requested.

i. Violating any provision of Iowa Code chapter 249A, or any rule promulgated pursuant thereto, or violating any federal or state false claims Act, including but not limited to Iowa Code chapter 685.

j. Submitting or causing to be submitted false, intentionally misleading, or fraudulent information in an application for provider status under the medical assistance program or any quality review or other submission required to maintain good standing in the program.

k. Violating any law, regulation, or code of ethics governing the conduct of an occupation, profession, or other regulated business activity, when the violation relates to, or arises out of, the delivery of services under the state medical assistance program.

l. Breaching any settlement or similar agreement with the department, or failing to abide by the terms of any agreement with any other entity relating to, or arising out of, the state medical assistance program.

m. Failing to meet standards required by state or federal law for participation, including but not limited to licensure.

n. Exclusion from Medicare or any other state or federally funded medical assistance program.

o. Except as authorized by law, charging a person for covered services over and above what the department paid or would pay or soliciting, offering, or receiving a kickback, bribe, or rebate, or accepting or rebating a fee or a charge for medical assistance or patient referral, or a portion thereof. This ground does not include the collection of a copayment or deductible if otherwise allowed by law.

p. Failing to correct a deficiency in provider operations after receiving notice of the deficiency from the department or other federal or state agency.

q. Formal reprimand or censure by an association of the provider's peers or similar entity related to professional conduct.

r. Suspension or termination for cause from participation in another program, including but not limited to workers' compensation or any publicly or privately funded health care program.

s. Indictment or other institution of criminal charges for, or plea of guilty or nolo contendere to, or conviction of, any crime punishable by a term of imprisonment greater than one year, any crime of violence, any controlled substance offense, or any crime involving an allegation of dishonesty or negligent practice resulting in death or injury to a provider's patient.

- t.* Violation of a condition of probation, suspension of payments, or other sanction.
- u.* Loss, restriction, or lack of hospital privileges for cause.
- v.* Negligent, reckless, or intentional endangerment of the health, welfare, or safety of a person.
- w.* Billing for services provided by an excluded, nonenrolled, terminated, suspended, or otherwise ineligible provider or person.
- x.* Failing to submit a self-assessment, corrective action plan, or other requirement for continued participation in the medical assistance program, or failing to repay an overpayment of medical assistance funds, in a timely manner, as set forth in a rule or other order.
- y.* Attempting, aiding or abetting, conspiring, or knowingly advising or encouraging another person in the commission of one or more of the grounds specified herein.

79.2(3) *Sanctions.*

- a.* The department may impose any of the following sanctions on any person:
 - (1) A term of probation for participation in the medical assistance program.
 - (2) Termination from participation in the medical assistance program.
 - (3) Suspension from participation in the medical assistance program.
 - (4) Suspension of payments in whole or in part.
 - (5) Prior authorization of services.
 - (6) Review of claims prior to payment.
- b.* The withholding of a payment or a recoupment of medical assistance funds is not, in itself, a sanction. Overpayments, civil monetary penalties, and interest may also be withheld from payments without imposition of a sanction.
- c.* Mandatory suspensions and terminations.
 - (1) Suspension or termination from participation in the medical assistance program is mandatory when a person is suspended or terminated from participation in the Medicare program, another state's medical assistance program, or by any licensing body. The suspension or termination from participation in the medical assistance program shall be retroactive to the date established by the Centers for Medicare and Medicaid Services or other state or body and, in the case of a suspension, must continue until at least such time as the Medicare or other state's or body's suspension ends.
 - (2) Termination is mandatory upon entry of final judgment, in the Iowa district court or a federal district court of the United States, of liability of the person in a false claims action.
 - (3) Suspension from participation is mandatory whenever a person, or an affiliate of the person, has an outstanding overpayment of medical assistance funds, as defined in Iowa Code chapter 249A.
 - (4) Upon notification from the U.S. Department of Justice, the Iowa department of justice, the department of inspections and appeals, or a similar agency, that a person has failed to respond to a civil investigative demand or other subpoena in a timely manner as set forth in governing law and the demand or other subpoena itself, the department shall immediately suspend the person from participation and suspend all payments to the person. The suspension and payment suspension shall end upon notification that the person has responded to the demand in full.

79.2(4) *Imposition and extent of sanction.* The department shall consider the totality of the circumstances in determining the sanctions to be imposed. The factors the department may consider include, but are not limited to:

- a.* Seriousness of the offense.
- b.* Extent of violations.
- c.* History of prior violations.
- d.* Prior imposition of sanctions.
- e.* Prior provision of provider education (technical assistance).
- f.* Provider willingness to obey program rules.
- g.* Whether a lesser sanction will be sufficient to remedy the problem.
- h.* Actions taken or recommended by peer review groups or licensing boards.

79.2(5) *Scope of sanction.*

a. Suspension or termination from participation shall preclude the person from submitting claims for payment, whether personally or through claims submitted by any other person or affiliate, for any services or supplies except for those services provided before the suspension or termination.

b. No person may submit claims for payment for any services or supplies provided by a person or affiliate who has been suspended or terminated from participation in the medical assistance program except for those services provided before the suspension or termination.

c. When the provisions of this subrule are violated, the department may sanction any person responsible for the violation.

79.2(6) *Notice to third parties.* When a sanction is imposed, the department may notify third parties of the findings made and the sanction imposed, including but not limited to law enforcement or peace officers and federal or state agencies. The imposition of a sanction is not required before the department may notify third parties of a person's conduct. In accordance with 42 CFR § 1002.212, the department must notify other state agencies, applicable licensing boards, the public, and Medicaid members, as provided in 42 CFR §§ 1001.2005 and 1001.2006, whenever the department initiates an exclusion under 42 CFR § 1002.210.

79.2(7) *Notice of violation.*

a. Any order of sanction shall be in writing and include the name of the person subject to sanction, identify the ground for the sanction and its effective date, and be sent to the person's last-known address. If the department sanctions a provider, the order of sanction shall also include the national provider identification number of the provider and be sent to the provider's last address on file within the medical assistance program. Proof of mailing to such address shall be conclusive evidence of proper service of the sanction upon the provider. The department of inspections and appeals is not required to comply with the additional notification provisions of 441—paragraph 7.10(7) “c” for appeals certified for hearing under this chapter.

b. In the case of a currently enrolled provider otherwise in good standing with all program requirements, the provider shall have 15 days subsequent to the date of the notice prior to the department action to show cause why the action should not be taken. If the provider fails to do so, the sanction shall remain effective pending any subsequent appeal under 441—Chapter 7. If the provider attempts to show cause but the department determines the sanction should remain effective pending any subsequent appeal under 441—Chapter 7, the provider may seek a temporary stay of the department's action from the director or the director's designee by filing an application for stay with the appeals section. The director or the director's designee shall consider the factors listed in Iowa Code section 17A.19(5) “c.”

79.2(8) *Suspension or withholding of payments.* The department may withhold payments on pending and subsequently received claims in an amount reasonably calculated to approximate the amounts in question due to a sanction, incorrect payment, civil monetary penalty, or other adverse action and may also suspend payment or participation pending a final determination. If the department withholds or suspends payments, it shall notify the person in writing within the time frames prescribed by federal law for cases related to a credible allegation of fraud, and within ten days for all other cases.

79.2(9) *Civil monetary penalties and interest.* Civil monetary penalties and interest assessed in accordance with 2013 Iowa Acts, Senate File 357, section 5 or section 11, are not allowable costs for any aspect of determining payment to a person within the medical assistance program. Under no circumstance shall the department reimburse a person for such civil monetary penalties or interest.

79.2(10) *Report and return of identified overpayment.*

a. If a person has identified an overpayment, the person must report and return the overpayment in the form and manner set forth in this subrule.

b. A person has identified an overpayment if the person has actual knowledge of the existence of the overpayment or acts in reckless disregard or deliberate ignorance of the existence of the overpayment.

c. An overpayment required to be reported under 2013 Iowa Acts, Senate File 357, section 3, must be made in writing, addressed to the Program Integrity Unit of the Iowa Medicaid Enterprise, and contain all of the following:

- (1) Person's name.

- (2) Person's tax identification number.
- (3) How the error was discovered.
- (4) The reason for the overpayment.
- (5) Claim number(s), as appropriate.
- (6) Date(s) of service.
- (7) Member identification number(s).
- (8) National provider identification (NPI) number.
- (9) Description of the corrective action plan to ensure the error does not occur again, if applicable.
- (10) Whether the person has a corporate integrity agreement with the Office of the Inspector General (OIG) or is under the OIG Self-Disclosure Protocol or is presently under sanction by the department.
- (11) The time frame and the total amount of refund for the period during which the problem existed that caused the refund.
- (12) If a statistical sample was used to determine the overpayment amount, a description of the statistically valid methodology used to determine the overpayment.
- (13) A refund in the amount of the overpayment.

This rule is intended to implement Iowa Code section 249A.4.

[ARC 1155C, IAB 10/30/13, effective 1/1/14; ARC 1695C, IAB 10/29/14, effective 1/1/15]

441—79.3(249A) Maintenance of records by providers of service. A provider of a service that is charged to the medical assistance program shall maintain complete and legible records as required in this rule. Failure to maintain records or failure to make records available to the department or to its authorized representative timely upon request shall result in claim denial or recoupment.

79.3(1) *Financial (fiscal) records.*

a. A provider of service shall maintain records as necessary to:

- (1) Support the determination of the provider's reimbursement rate under the medical assistance program; and
- (2) Support each item of service for which a charge is made to the medical assistance program. These records include financial records and other records as may be necessary for reporting and accountability.

b. A financial record does not constitute a medical record.

79.3(2) *Medical (clinical) records.* A provider of service shall maintain complete and legible medical records for each service for which a charge is made to the medical assistance program. Required records shall include any records required to maintain the provider's license in good standing.

a. Definition. "Medical record" (also called "clinical record") means a tangible history that provides evidence of:

- (1) The provision of each service and each activity billed to the program; and
- (2) First and last name of the member receiving the service.

b. Purpose. The medical record shall provide evidence that the service provided is:

- (1) Medically necessary;
- (2) Consistent with the diagnosis of the member's condition; and
- (3) Consistent with professionally recognized standards of care.

c. Components.

(1) *Identification.* Each page or separate electronic document of the medical record shall contain the member's first and last name. In the case of electronic documents, the member's first and last name must appear on each screen when viewed electronically and on each page when printed. As part of the medical record, the medical assistance identification number and the date of birth must also be identified and associated with the member's first and last name.

(2) *Basis for service—general rule.* General requirements for all services are listed herein. For the application of these requirements to specific services, see paragraph 79.3(2) "*d.*" The medical record shall reflect the reason for performing the service or activity, substantiate medical necessity, and demonstrate the level of care associated with the service. The medical record shall include the items specified below unless the listed item is not routinely received or created in connection with a particular service or activity

and is not required to document the reason for performing the service or activity, the medical necessity of the service or activity, or the level of care associated with the service or activity:

1. The member's complaint, symptoms, and diagnosis.
2. The member's medical or social history.
3. Examination findings.
4. Diagnostic test reports, laboratory test results, or X-ray reports.
5. Goals or needs identified in the member's plan of care.
6. Physician orders and any prior authorizations required for Medicaid payment.
7. Medication records, pharmacy records for prescriptions, or providers' orders.
8. Related professional consultation reports.
9. Progress or status notes for the services or activities provided.
10. All forms required by the department as a condition of payment for the services provided.
11. Any treatment plan, care plan, service plan, individual health plan, behavioral intervention plan, or individualized education program.

12. The provider's assessment, clinical impression, diagnosis, or narrative, including the complete date thereof and the identity of the person performing the assessment, clinical impression, diagnosis, or narrative.

13. Any additional documentation necessary to demonstrate the medical necessity of the service provided or otherwise required for Medicaid payment.

(3) Service documentation. The record for each service provided shall include information necessary to substantiate that the service was provided and shall include the following:

1. The specific procedures or treatments performed.
2. The complete date of the service, including the beginning and ending date if the service is rendered over more than one day.
3. The complete time of the service, including the beginning and ending time if the service is billed on a time-related basis. For those non-time-related services billed using Current Procedural Terminology (CPT) codes, the total time of the service shall be recorded, rather than the beginning and ending time.
4. The location where the service was provided if otherwise required on the billing form or in 441—paragraph 77.30(5)“c” or “d,” 441—paragraph 77.33(6)“d,” 441—paragraph 77.34(5)“d,” 441—paragraph 77.37(15)“d,” 441—paragraph 77.39(13)“e,” 441—paragraph 77.39(14)“d,” or 441—paragraph 77.46(5)“i,” or 441—subparagraph 78.9(10)“a”(1).
5. The name, dosage, and route of administration of any medication dispensed or administered as part of the service.
6. Any supplies dispensed as part of the service.
7. The first and last name and professional credentials, if any, of the person providing the service.
8. The signature of the person providing the service, or the initials of the person providing the service if a signature log indicates the person's identity.

9. For 24-hour care, documentation for every shift of the services provided, the member's response to the services provided, and the person who provided the services.

(4) Outcome of service. The medical record shall indicate the member's progress in response to the services rendered, including any changes in treatment, alteration of the plan of care, or revision of the diagnosis.

d. Basis for service requirements for specific services. The medical record for the following services must include, but is not limited to, the items specified below (unless the listed item is not routinely received or created in connection with the particular service or activity and is not required to document the reason for performing the service or activity, its medical necessity, or the level of care associated with it). These items will be specified on Form 470-4479, Documentation Checklist, when the Iowa Medicaid enterprise program integrity unit requests providers to submit records for review. (See paragraph 79.4(2)“b.”)

- (1) Physician (MD and DO) services:
 1. Service or office notes or narratives.
 2. Procedure, laboratory, or test orders and results.

- (2) Pharmacy services:
 1. Prescriptions.
 2. Nursing facility physician order.
 3. Telephone order.
 4. Pharmacy notes.
 5. Prior authorization documentation.
- (3) Dentist services:
 1. Treatment notes.
 2. Anesthesia notes and records.
 3. Prescriptions.
- (4) Podiatrist services:
 1. Service or office notes or narratives.
 2. Certifying physician statement.
 3. Prescription or order form.
- (5) Certified registered nurse anesthetist services:
 1. Service notes or narratives.
 2. Preanesthesia physical examination report.
 3. Operative report.
 4. Anesthesia record.
 5. Prescriptions.
- (6) Other advanced registered nurse practitioner services:
 1. Service or office notes or narratives.
 2. Procedure, laboratory, or test orders and results.
- (7) Optometrist and optician services:
 1. Notes or narratives supporting eye examinations, medical services, and auxiliary procedures.
 2. Original prescription or updated prescriptions for corrective lenses or contact lenses.
 3. Prior authorization documentation.
- (8) Psychologist services:
 1. Service or office psychotherapy notes or narratives.
 2. Psychological examination report and notes.
- (9) Clinic services:
 1. Service or office notes or narratives.
 2. Procedure, laboratory, or test orders and results.
 3. Nurses' notes.
 4. Prescriptions.
 5. Medication administration records.
- (10) Services provided by rural health clinics or federally qualified health centers:
 1. Service or office notes or narratives.
 2. Form 470-2942, Prenatal Risk Assessment.
 3. Procedure, laboratory, or test orders and results.
 4. Immunization records.
- (11) Services provided by community mental health centers:
 1. Service referral documentation.
 2. Initial evaluation.
 3. Individual treatment plan.
 4. Service or office notes or narratives.
 5. Narratives related to the peer review process and peer review activities related to a member's treatment.
 6. Written plan for accessing emergency services.
- (12) Screening center services:
 1. Service or office notes or narratives.
 2. Immunization records.

3. Laboratory reports.
4. Results of health, vision, or hearing screenings.
- (13) Family planning services:
 1. Service or office notes or narratives.
 2. Procedure, laboratory, or test orders and results.
 3. Nurses' notes.
 4. Immunization records.
 5. Consent forms.
 6. Prescriptions.
 7. Medication administration records.
- (14) Maternal health center services:
 1. Service or office notes or narratives.
 2. Procedure, laboratory, or test orders and results.
 3. Form 470-2942, Prenatal Risk Assessment.
- (15) Birthing center services:
 1. Service or office notes or narratives.
 2. Form 470-2942, Prenatal Risk Assessment.
- (16) Ambulatory surgical center services:
 1. Service notes or narratives (history and physical, consultation, operative report, discharge summary).
 2. Physician orders.
 3. Consent forms.
 4. Anesthesia records.
 5. Pathology reports.
 6. Laboratory and X-ray reports.
- (17) Hospital services:
 1. Physician orders.
 2. Service notes or narratives (history and physical, consultation, operative report, discharge summary).
 3. Progress or status notes.
 4. Diagnostic procedures, including laboratory and X-ray reports.
 5. Pathology reports.
 6. Anesthesia records.
 7. Medication administration records.
- (18) State mental hospital services:
 1. Service referral documentation.
 2. Resident assessment and initial evaluation.
 3. Individual comprehensive treatment plan.
 4. Service notes or narratives (history and physical, therapy records, discharge summary).
 5. Form 470-0042, Case Activity Report.
 6. Medication administration records.
- (19) Services provided by skilled nursing facilities, nursing facilities, and nursing facilities for persons with mental illness:
 1. Physician orders.
 2. Progress or status notes.
 3. Service notes or narratives.
 4. Procedure, laboratory, or test orders and results.
 5. Nurses' notes.
 6. Physical therapy, occupational therapy, and speech therapy notes.
 7. Medication administration records.
 8. Form 470-0042, Case Activity Report.
- (20) Services provided by intermediate care facilities for persons with mental retardation:

1. Physician orders.
2. Progress or status notes.
3. Preliminary evaluation.
4. Comprehensive functional assessment.
5. Individual program plan.
6. Form 470-0374, Resident Care Agreement.
7. Program documentation.
8. Medication administration records.
9. Nurses' notes.
10. Form 470-0042, Case Activity Report.
- (21) Services provided by psychiatric medical institutions for children:
 1. Physician orders or court orders.
 2. Independent assessment.
 3. Individual treatment plan.
 4. Service notes or narratives (history and physical, therapy records, discharge summary).
 5. Form 470-0042, Case Activity Report.
 6. Medication administration records.
- (22) Hospice services:
 1. Physician certifications for hospice care.
 2. Form 470-2618, Election of Medicaid Hospice Benefit.
 3. Form 470-2619, Revocation of Medicaid Hospice Benefit.
 4. Plan of care.
 5. Physician orders.
 6. Progress or status notes.
 7. Service notes or narratives.
 8. Medication administration records.
 9. Prescriptions.
- (23) Services provided by rehabilitation agencies:
 1. Physician orders.
 2. Initial certification, recertifications, and treatment plans.
 3. Narratives from treatment sessions.
 4. Treatment and daily progress or status notes and forms.
- (24) Home- and community-based habilitation services:
 1. Notice of decision for service authorization.
 2. Service plan (initial and subsequent).
 3. Service notes or narratives.
- (25) Behavioral health intervention:
 1. Order for services.
 2. Comprehensive treatment or service plan (initial and subsequent).
 3. Service notes or narratives.
- (26) Services provided by area education agencies and local education agencies:
 1. Service notes or narratives.
 2. Individualized education program (IEP).
 3. Individual health plan (IHP).
 4. Behavioral intervention plan.
- (27) Home health agency services:
 1. Plan of care or plan of treatment.
 2. Certifications and recertifications.
 3. Service notes or narratives.
 4. Physician orders or medical orders.
- (28) Services provided by independent laboratories:
 1. Laboratory reports.

2. Physician order for each laboratory test.
- (29) Ambulance services:
 1. Documentation on the claim or run report supporting medical necessity of the transport.
 2. Documentation supporting mileage billed.
- (30) Services of lead investigation agencies:
 1. Service notes or narratives.
 2. Child's lead level logs (including laboratory results).
 3. Written investigation reports to family, owner of building, child's medical provider, and local childhood lead poisoning prevention program.
 4. Health education notes, including follow-up notes.
- (31) Medical supplies:
 1. Prescriptions.
 2. Certificate of medical necessity.
 3. Prior authorization documentation.
 4. Medical equipment invoice or receipt.
- (32) Orthopedic shoe dealer services:
 1. Service notes or narratives.
 2. Prescriptions.
 3. Certifying physician's statement.
- (33) Case management services, including HCBS case management services:
 1. Form 470-3956, MR/CMI/DD Case Management Service Authorization Request, for services authorized before May 1, 2007.
 2. Notice of decision for service authorization.
 3. Service notes or narratives.
 4. Social history.
 5. Comprehensive service plan.
 6. Reassessment of member needs.
 7. Incident reports in accordance with 441—subrule 24.4(5).
- (34) Early access service coordinator services:
 1. Individualized family service plan (IFSP).
 2. Service notes or narratives.
- (35) Home- and community-based waiver services, other than case management:
 1. Notice of decision for service authorization.
 2. Service plan.
 3. Service logs, notes, or narratives.
 4. Mileage and transportation logs.
 5. Log of meal delivery.
 6. Invoices or receipts.
 7. Forms 470-3372, HCBS Consumer-Directed Attendant Care Agreement, and 470-4389, Consumer-Directed Attendant Care (CDAC) Service Record.
- (36) Physical therapist services:
 1. Physician order for physical therapy.
 2. Initial physical therapy certification, recertifications, and treatment plans.
 3. Treatment notes and forms.
 4. Progress or status notes.
- (37) Chiropractor services:
 1. Service or office notes or narratives.
 2. X-ray results.
- (38) Hearing aid dealer and audiologist services:
 1. Physician examinations and audiological testing (Form 470-0361, Sections A, B, and C).
 2. Documentation of hearing aid evaluation and selection (Form 470-0828).
 3. Waiver of informed consent.

4. Prior authorization documentation.
5. Service or office notes or narratives.
- (39) Behavioral health services:
 1. Assessment.
 2. Individual treatment plan.
 3. Service or office notes or narratives.
- (40) Health home services:
 1. Comprehensive care management plan.
 2. Care coordination and health promotion plan.
 3. Comprehensive transitional care plan, including appropriate follow-up, from inpatient to other settings.
 4. Documentation of member and family support (including authorized representatives).
 5. Documentation of referral to community and social support services, if relevant.
- (41) Services of public health agencies:
 1. Service or office notes or narratives.
 2. Immunization records.
 3. Results of communicable disease testing.
- e. Corrections.* A provider may correct the medical record before submitting a claim for reimbursement.

(1) Corrections must be made or authorized by the person who provided the service or by a person who has first-hand knowledge of the service.

(2) A correction to a medical record must not be written over or otherwise obliterate the original entry. A single line may be drawn through erroneous information, keeping the original entry legible. In the case of electronic records, the original information must be retained and retrievable.

(3) Any correction must indicate the person making the change and any other person authorizing the change, must be dated and signed by the person making the change, and must be clearly connected with the original entry in the record.

(4) If a correction made after a claim has been submitted affects the accuracy or validity of the claim, an amended claim must be submitted.

79.3(3) Maintenance requirement. The provider shall maintain records as required by this rule:

- a.* During the time the member is receiving services from the provider.
- b.* For a minimum of five years from the date when a claim for the service was submitted to the medical assistance program for payment.
- c.* As may be required by any licensing authority or accrediting body associated with determining the provider's qualifications.

79.3(4) Availability. Rescinded IAB 1/30/08, effective 4/1/08.

This rule is intended to implement Iowa Code section 249A.4.

[ARC 7957B, IAB 7/15/09, effective 7/1/09; ARC 8262B, IAB 11/4/09, effective 12/9/09; ARC 9440B, IAB 4/6/11, effective 4/1/11; ARC 9487B, IAB 5/4/11, effective 7/1/11; ARC 0198C, IAB 7/11/12, effective 7/1/12; ARC 0358C, IAB 10/3/12, effective 11/7/12; ARC 0711C, IAB 5/1/13, effective 7/1/13; ARC 1695C, IAB 10/29/14, effective 1/1/15]

441—79.4(249A) Reviews and audits.

79.4(1) Definitions.

“Authorized representative,” within the context of this rule, means the person appointed to carry out audit or review procedures, including assigned auditors, reviewers or agents contracted for specific audits, reviews, or audit or review procedures.

“Claim” means each record received by the department or the Iowa Medicaid enterprise that states the amount of requested payment and the service rendered by a specific and particular Medicaid provider to an eligible member.

“Clinical record” means a legible electronic or hard-copy history that documents the criteria established for medical records as set forth in rule 441—79.3(249A). A claim form or billing statement does not constitute a clinical record.

“Confidence level” means the statistical reliability of the sampling parameters used to estimate the proportion of payment errors (overpayment and underpayment) in the universe under review.

“Customary and prevailing fee” means a fee that is both (1) the most consistent charge by a Medicaid provider for a given service and (2) within the range of usual charges for a given service billed by most providers with similar training and experience in the state of Iowa.

“Extrapolation” means that the total amount of overpayment or underpayment will be determined by using sample data meeting the confidence level requirement.

“Fiscal record” means a legible electronic or hard-copy history that documents the criteria established for fiscal records as set forth in rule 441—79.3(249A). A claim form or billing statement does not constitute a fiscal record.

“Overpayment” means any payment or portion of a payment made to a provider that is incorrect according to the laws and rules applicable to the Medicaid program and that results in a payment greater than that to which the provider is entitled.

“Procedure code” means the identifier that describes medical or remedial services performed or the supplies, drugs, or equipment provided.

“Random sample” means a statistically valid random sample for which the probability of selection for every item in the universe is known.

“Underpayment” means any payment or portion of a payment not made to a provider for services delivered to eligible members according to the laws and rules applicable to the Medicaid program and to which the provider is entitled.

“Universe” means all items or claims under review or audit during the period specified by the audit or review.

79.4(2) *Audit or review of clinical and fiscal records by the department.* Any Medicaid provider may be audited or reviewed at any time at the discretion of the department.

a. Authorized representatives of the department shall have the right, upon proper identification, to audit or review the clinical and fiscal records to determine whether:

- (1) The department has correctly paid claims for goods or services.
- (2) The provider has furnished the services to Medicaid members.
- (3) The provider has retained clinical and fiscal records that substantiate claims submitted for payment.
- (4) The goods or services provided were in accordance with Iowa Medicaid policy.

b. Requests for provider records by the Iowa Medicaid enterprise program integrity unit shall include Form 470-4479, Documentation Checklist, which is available at www.ime.state.ia.us/Providers/Forms.html, listing the specific records that must be provided for the audit or review pursuant to paragraph 79.3(2)“d” to document the basis for services or activities provided.

c. Records generated and maintained by the department may be used by auditors or reviewers and in all proceedings of the department.

79.4(3) *Audit or review procedures.* The department will select the method of conducting an audit or review and will protect the confidential nature of the records being audited or reviewed. The provider may be required to furnish records to the department. Unless the department specifies otherwise, the provider may select the method of delivering any requested records to the department.

a. Upon a written request for records, the provider must submit all responsive records to the department or its authorized agent within 30 calendar days of the mailing date of the request, except as provided in paragraph “b.”

b. Extension of time limit for submission.

(1) The department may grant an extension to the required submission date of up to 15 calendar days upon written request from the provider or the provider’s designee. The request must:

1. Establish good cause for the delay in submitting the records; and
2. Be received by the department before the date the records are due to be submitted.

(2) For purposes of these rules, “good cause” has the same meaning as in Iowa Rule of Civil Procedure 1.977.

(3) The department may grant a request for an extension of the time limit for submitting records at its discretion. The department shall issue a written notice of its decision.

(4) The provider may appeal the department's denial of a request to extend the time limit for submission of requested records according to the procedures in 441—Chapter 7.

c. The department may elect to conduct announced or unannounced on-site reviews or audits. Records must be provided upon request and before the end of the on-site review or audit.

(1) For an announced on-site review or audit, the department's employee or authorized agent may give as little as one day's advance notice of the review or audit and the records and supporting documentation to be reviewed.

(2) Notice is not required for unannounced on-site reviews and audits.

(3) In an on-site review or audit, the conclusion of that review or audit shall be considered the end of the period within which to produce records.

d. Audit or review procedures may include, but are not limited to, the following:

(1) Comparing clinical and fiscal records with each claim.

(2) Interviewing members who received goods or services and employees of providers.

(3) Examining third-party payment records.

(4) Comparing Medicaid charges with private-patient charges to determine that the charge to Medicaid is not more than the customary and prevailing fee.

(5) Examining all documents related to the services for which Medicaid was billed.

e. Use of statistical sampling techniques. The department's procedures for auditing or reviewing Medicaid providers may include the use of random sampling and extrapolation.

(1) A statistically valid random sample will be selected from the universe of records to be audited or reviewed. The sample size shall be selected using accepted sample size estimation methods. The confidence level of the sample size calculation shall not be less than 95 percent.

(2) Following the sample audit or review, the statistical margin of error of the sample will be computed, and a confidence interval will be determined. The estimated error rate will be extrapolated to the universe from which the sample was drawn within the computed margin of error of the sampling process.

(3) Commonly accepted statistical analysis programs may be used to estimate the sample size and calculate the confidence interval, consistent with the sampling parameters.

(4) The audit or review findings generated through statistical sampling procedures shall constitute prima facie evidence in all department proceedings regarding the number and amount of overpayments or underpayments received by the provider.

f. Self-audit. The department may require a provider to conduct a self-audit and report the results of the self-audit to the department.

79.4(4) Preliminary report of audit or review findings. If the department concludes from an audit or review that an overpayment has occurred, the department will issue a preliminary finding of a tentative overpayment and inform the provider of the opportunity to request a reevaluation.

79.4(5) Disagreement with audit or review findings. If a provider disagrees with the preliminary finding of a tentative overpayment, the provider may request a reevaluation by the department and may present clarifying information and supplemental documentation.

a. *Reevaluation request.* A request for reevaluation must be submitted in writing within 15 calendar days of the date of the notice of the preliminary finding of a tentative overpayment. The request must specify the issues of disagreement.

(1) If the audit or review is being performed by the Iowa Medicaid enterprise surveillance and utilization review services unit, the request should be addressed to: IME SURS Unit, P.O. Box 36390, Des Moines, Iowa 50315.

(2) If the audit or review is being performed by any other departmental entity, the request should be addressed to: Iowa Department of Human Services, Attention: Fiscal Management Division, Hoover State Office Building, 1305 E. Walnut Street, Des Moines, Iowa 50319-0114.

b. *Additional information.* A provider that has made a reevaluation request pursuant to paragraph "a" of this subrule may submit clarifying information or supplemental documentation that was not

previously provided. This information must be received at the applicable address within 30 calendar days of the mailing of the preliminary finding of a tentative overpayment to the provider, except as provided in paragraph “c” of this subrule.

c. Disagreement with sampling results. When the department’s audit or review findings have been generated through sampling and extrapolation and the provider disagrees with the findings, the burden of proof of compliance rests with the provider. The provider may present evidence to show that the sample was invalid. The evidence may include a 100 percent audit or review of the universe of provider records used by the department in the drawing of the department’s sample. Any such audit or review must:

- (1) Be arranged and paid for by the provider.
- (2) Be conducted by an individual or organization with expertise in coding, medical services, and Iowa Medicaid policy if the issues relate to clinical records.
- (3) Be conducted by a certified public accountant if the issues relate to fiscal records.
- (4) Demonstrate that bills and records that were not audited or reviewed in the department’s sample are in compliance with program regulations.
- (5) Be submitted to the department with all supporting documentation within 60 calendar days of the mailing of the preliminary finding of a tentative overpayment to the provider.

79.4(6) Finding and order for repayment. Upon completion of a requested reevaluation or upon expiration of the time to request reevaluation, the department shall issue a finding and order for repayment of any overpayment and may immediately begin withholding payments on other claims to recover any overpayment.

79.4(7) Appeal by provider of care. A provider may appeal the finding and order of repayment and withholding of payments pursuant to 441—Chapter 7. However, an appeal shall not stay the withholding of payments or other action to collect the overpayment. Records not provided to the department during the review process set forth in subrule 79.4(3) or 79.4(5) shall not be admissible in any subsequent contested case proceeding arising out of a finding and order for repayment of any overpayment identified under subrule 79.4(6). This provision does not preclude providers that have provided records to the department during the review process set forth in subrule 79.4(3) or 79.4(5) from presenting clarifying information or supplemental documentation in the appeals process in order to defend against any overpayment identified under subrule 79.4(6). This provision is intended to minimize potential duplication of effort and delay in the audit or review process, minimize unnecessary appeals, and otherwise forestall fraud, waste, and abuse in the Iowa Medicaid program.

This rule is intended to implement Iowa Code section 249A.4.
[ARC 0712C, IAB 5/1/13, effective 7/1/13; ARC 1155C, IAB 10/30/13, effective 1/1/14]

441—79.5(249A) Nondiscrimination on the basis of handicap. All providers of service shall comply with Section 504 of the Rehabilitation Act of 1973 and Federal regulations 45 CFR Part 84, as amended to December 19, 1990, which prohibit discrimination on the basis of handicap in all Department of Health and Human Services funded programs.

This rule is intended to implement Iowa Code subsection 249A.4(6).

441—79.6(249A) Provider participation agreement. Providers of medical and health care wishing to participate in the program shall execute an agreement with the department on Form 470-2965, Agreement Between Provider of Medical and Health Services and the Iowa Department of Human Services Regarding Participation in Medical Assistance Program.

EXCEPTION: Dental providers are required to complete Form 470-3174, Addendum to Dental Provider Agreement for Orthodontia, to receive reimbursement under the early and periodic screening, diagnosis, and treatment program.

In these agreements, the provider agrees to the following:

79.6(1) To maintain clinical and fiscal records as specified in rule 441—79.3(249A).

79.6(2) That the charges as determined in accordance with the department’s policy shall be the full and complete charge for the services provided and no additional payment shall be claimed from the recipient or any other person for services provided under the program.

79.6(3) That it is understood that payment in satisfaction of the claim will be from federal and state funds and any false claims, statements, or documents, or concealment of a material fact may be prosecuted under applicable federal and state laws.

This rule is intended to implement Iowa Code section 249A.4.

441—79.7(249A) Medical assistance advisory council.

79.7(1) Officers. Officers shall be a chairperson and a vice-chairperson.

a. The director of public health shall serve as chairperson of the council. Elections for vice-chairperson will be held the first meeting after the beginning of the calendar year.

b. The vice-chairperson's term of office shall be two years. A vice-chairperson shall serve no more than two terms.

c. The vice-chairperson shall serve in the absence of the chairperson.

d. The chairperson and vice-chairperson shall have the right to vote on any issue before the council.

e. The chairperson shall appoint a committee of not less than three members to nominate vice-chairpersons and shall appoint other committees approved by the council.

79.7(2) Membership. The membership of the council and its executive committee shall be as prescribed at Iowa Code section 249A.4B, subsections 2 and 3.

79.7(3) Expenses, staff support, and technical assistance. Expenses of the council and executive committee, such as those for clerical services, mailing, telephone, and meeting place, shall be the responsibility of the department of human services. The department shall arrange for a meeting place, related services, and accommodations. The department shall provide staff support and independent technical assistance to the council and the executive committee.

79.7(4) Meetings. The council shall meet no more than quarterly. The executive committee shall meet on a monthly basis. Meetings may be called by the chairperson, upon written request of at least 50 percent of the members, or by the director of the department of human services.

a. Meetings shall be held in the Des Moines, Iowa, area, unless other notification is given.

b. Written notice of council meetings shall be mailed at least two weeks in advance of the meeting. Each notice shall include an agenda for the meeting.

79.7(5) Procedures.

a. A quorum shall consist of 50 percent of the voting members.

b. Where a quorum is present, a position is carried by two-thirds of the council members present.

c. Minutes of council meetings and other written materials developed by the council shall be distributed by the department to each member and to the executive office of each professional group or business entity represented.

d. Notice shall be given to a professional group or business entity represented on the council when the representative of that group or entity has been absent from three consecutive meetings.

e. In cases not covered by these rules, Robert's Rules of Order shall govern.

79.7(6) Duties.

a. Executive committee. Based upon the deliberations of the medical assistance advisory council and the executive committee, the executive committee shall make recommendations to the director regarding the budget, policy, and administration of the medical assistance program. Such recommendations may include:

(1) Recommendations on the reimbursement for medical services rendered by providers of services.

(2) Identification of unmet medical needs and maintenance needs which affect health.

(3) Recommendations for objectives of the program and for methods of program analysis and evaluation, including utilization review.

(4) Recommendations for ways in which needed medical supplies and services can be made available most effectively and economically to the program recipients.

(5) Advice on such administrative and fiscal matters as the director of the department of human services may request.

b. Council. The medical assistance advisory council shall:

- (1) Advise the professional groups and business entities represented and act as liaison between them and the department.
- (2) Report at least annually to the professional groups and business entities represented.
- (3) Perform other functions as may be provided by state or federal law or regulation.
- (4) Communicate information considered by the council to the professional groups and business entities represented.

79.7(7) Responsibilities.

a. Recommendations of the council shall be advisory and not binding upon the department of human services or the professional groups and business entities represented. The director of the department of human services shall consider the recommendations offered by the council and the executive committee in:

(1) The director's preparation of medical assistance budget recommendations to the council on human services, pursuant to Iowa Code section 217.3, and

(2) Implementation of medical assistance program policies.

b. The council may choose subjects for consideration and recommendation. It shall consider all matters referred to it by the department of human services.

c. Any matter referred by a member organization or body shall be considered upon an affirmative vote of the council.

d. The department shall provide the council with reports, data, and proposed and final amendments to rules, laws, and guidelines, for its information, review, and comment.

e. The department shall present the annual budget for the medical assistance program for review and comment.

f. The department shall permit staff members to appear before the council to review and discuss specific information and problems.

g. The department shall maintain a current list of members on the council and executive committee.

[ARC 8263B, IAB 11/4/09, effective 12/9/09]

441—79.8(249A) Requests for prior authorization. When the Iowa Medicaid enterprise has not reached a decision on a request for prior authorization after 60 days from the date of receipt, the request will be approved.

79.8(1) Making the request.

a. Providers may submit requests for prior authorization for any items or procedures by mail or by facsimile transmission (fax) using Form 470-0829, Request for Prior Authorization, or electronically using the Accredited Standards Committee (ASC) X12N 278 transaction, Health Care Services Request for Review and Response. Requests for prior authorization for drugs may also be made by telephone.

b. Providers shall send requests for prior authorization to the Iowa Medicaid enterprise. The request should address the relevant criteria applicable to the particular service, medication or equipment for which prior authorization is sought, according to rule 441—78.28(249A). Copies of history and examination results may be attached to rather than incorporated in the letter.

c. If a request for prior authorization submitted electronically requires attachments or supporting clinical documentation and a national electronic attachment has not been adopted, the provider shall:

(1) Use Form 470-3970, Prior Authorization Attachment Control, as the cover sheet for the paper attachments or supporting clinical documentation; and

(2) Reference on Form 470-3970 the attachment control number submitted on the ASC X12N 278 electronic transaction.

79.8(2) The policy applies to services or items specifically designated as requiring prior authorization.

79.8(3) The provider shall receive a notice of approval or denial for all requests.

a. In the case of prescription drugs, notices of approval or denial will be faxed to the prescriber and pharmacy.

b. Decisions regarding approval or denial will be made within 24 hours from the receipt of the prior authorization request. In cases where the request is received during nonworking hours, the time limit will be construed to start with the first hour of the normal working day following the receipt of the request.

79.8(4) Prior authorizations approved because a decision is not timely made shall not be considered a precedent for future similar requests.

79.8(5) Approved prior authorization applies to covered services and does not apply to the recipient's eligibility for medical assistance.

79.8(6) If a provider is unsure if an item or service is covered because it is rare or unusual, the provider may submit a request for prior approval in the same manner as other requests for prior approval in 79.8(1).

79.8(7) Requests for prior approval of services shall be reviewed according to rule 441—79.9(249A) and the conditions for payment as established by rule in 441—Chapter 78. Where ambiguity exists as to whether a particular item or service is covered, requests for prior approval shall be reviewed according to the following criteria in order of priority:

a. The conditions for payment outlined in the provider manual with reference to coverage and duration.

b. The determination made by the Medicare program unless specifically stated differently in state law or rule.

c. The recommendation to the department from the appropriate advisory committee.

d. Whether there are other less expensive procedures which are covered and which would be as effective.

e. The advice of an appropriate professional consultant.

79.8(8) The amount, duration and scope of the Medicaid program is outlined in 441—Chapters 78, 79, 81, 82 and 85. Additional clarification of the policies is available in the provider manual distributed and updated to all participating providers.

79.8(9) The Iowa Medicaid enterprise shall issue a notice of decision to the recipient upon a denial of request for prior approval pursuant to 441—Chapter 7. The Iowa Medicaid enterprise shall mail the notice of decision to the recipient within five working days of the date the prior approval form is returned to the provider.

79.8(10) If a request for prior approval is denied by the Iowa Medicaid enterprise, the request may be resubmitted for reconsideration with additional information justifying the request. The aggrieved party may file an appeal in accordance with 441—Chapter 7.

This rule is intended to implement Iowa Code section 249A.4.

441—79.9(249A) General provisions for Medicaid coverage applicable to all Medicaid providers and services.

79.9(1) Medicare definitions and policies shall apply to services provided unless specifically defined differently.

79.9(2) The services covered by Medicaid shall:

a. Be consistent with the diagnosis and treatment of the patient's condition.

b. Be in accordance with standards of good medical practice.

c. Be required to meet the medical need of the patient and be for reasons other than the convenience of the patient or the patient's practitioner or caregiver.

d. Be the least costly type of service which would reasonably meet the medical need of the patient.

e. Be eligible for federal financial participation unless specifically covered by state law or rule.

f. Be within the scope of the licensure of the provider.

g. Be provided with the full knowledge and consent of the recipient or someone acting in the recipient's behalf unless otherwise required by law or court order or in emergency situations.

h. Be supplied by a provider who is eligible to participate in the Medicaid program. The provider must use the billing procedures and documentation requirements described in 441—Chapters 78 and 80.

79.9(3) Providers shall supply all the same services to Medicaid eligibles served by the provider as are offered to other clients of the provider.

79.9(4) Recipients must be informed before the service is provided that the recipient will be responsible for the bill if a noncovered service is provided.

79.9(5) Coverage in public institutions. Medical services provided to a person while the person is an inmate of a public jail, prison, juvenile detention center, or other public penal institution of more than four beds are not covered by Medicaid.

79.9(6) The acceptance of Medicaid funds by means of a prospective or interim rate creates an express trust. The Medicaid funds received constitute the trust res. The trust terminates when the rate is retrospectively adjusted or otherwise finalized and, if applicable, any Medicaid funds determined to be owed are repaid in full to the department.

79.9(7) Incorrect payment.

a. Except as provided in paragraph 79.9(7) “*b*,” medical assistance funds are incorrectly paid whenever an individual who provided the service to the member for which the department paid was at the time service was provided the parent of a minor child, spouse, or legal representative of the member.

b. Notwithstanding paragraph 79.9(7) “*a*,” medical assistance funds are not incorrectly paid when an individual who serves as a member’s legal representative provides services to the member under a home- and community-based services waiver consumer-directed attendant care agreement or under a consumer choices option employment agreement in effect on or after December 31, 2013. For purposes of this paragraph, “legal representative” means a person, including an attorney, who is authorized by law to act on behalf of the medical assistance program member but does not include the spouse of a member or the parent or stepparent of a member aged 17 or younger.

79.9(8) The rules of the medical assistance program shall not be construed to require payment of medical assistance funds, in whole or in part, directly or indirectly, overtly or covertly, for the provision of non-Medicaid services. The rules of the medical assistance program shall be interpreted in such a manner to minimize any risk that medical assistance funds might be used to subsidize services to persons other than members of the medical assistance program.

This rule is intended to implement Iowa Code section 249A.4 and 2014 Iowa Acts, Senate File 2320. [ARC 1155C, IAB 10/30/13, effective 1/1/14; ARC 1610C, IAB 9/3/14, effective 8/13/14]

441—79.10(249A) Requests for preadmission review. The inpatient hospitalization of Medicaid recipients is subject to preadmission review by the Iowa Medicaid enterprise (IME) medical services unit as required in rule 441—78.3(249A).

79.10(1) The patient’s admitting physician, the physician’s designee, or the hospital will contact the IME medical services unit to request approval of Medicaid coverage for the hospitalization, according to instructions issued to providers by the IME medical services unit and instructions in the Medicaid provider manual.

79.10(2) Medicaid payment will not be made to the hospital if the IME medical services unit denies the procedure requested in the preadmission review.

79.10(3) The IME medical services unit shall issue a letter of denial to the patient, the physician, and the hospital when a request is denied. The patient, the physician, or the hospital may request a reconsideration of the decision by filing a written request with the IME medical services unit within 60 days of the date of the denial letter.

79.10(4) The aggrieved party may appeal a denial of a request for reconsideration by the IME medical services unit according to 441—Chapter 7.

79.10(5) The requirement to obtain preadmission review is waived when the patient is enrolled in the managed health care option known as patient management and proper authorization for the admission has been obtained from the patient manager as described in 441—Chapter 88.

This rule is intended to implement Iowa Code section 249A.4.

441—79.11(249A) Requests for preprocedure surgical review. The Iowa Medicaid enterprise (IME) medical services unit conducts a preprocedure review of certain frequently performed surgical

procedures to determine the necessity of the procedures and if Medicaid payment will be approved according to requirements found in 441—subrules 78.1(19), 78.3(18), and 78.26(3).

79.11(1) The physician must request approval from the IME medical services unit when the physician expects to perform a surgical procedure appearing on the department's preprocedure surgical review list published in the Medicaid provider manual. All requests for preprocedure surgical review shall be made according to instructions issued to physicians, hospitals and ambulatory surgical centers appearing in the Medicaid provider manual and instructions issued to providers by the IME medical services unit.

79.11(2) The IME medical services unit shall issue the physician a validation number for each request and shall advise whether payment for the procedure will be approved or denied.

79.11(3) Medicaid payment will not be made to the physician and other medical personnel or the facility in which the procedure is performed, i.e., hospital or ambulatory surgical center, if the IME medical services unit does not give approval.

79.11(4) The IME medical services unit shall issue a denial letter to the patient, the physician, and the facility when the requested procedure is not approved. The patient, the physician, or the facility may request a reconsideration of the decision by filing a written request with the IME medical services unit within 60 days of the date of the denial letter.

79.11(5) The aggrieved party may appeal a denial of a request for reconsideration by the IME medical services unit in accordance with 441—Chapter 7.

79.11(6) The requirement to obtain preprocedure surgical review is waived when the patient is enrolled in the managed health care option known as patient management and proper authorization for the procedure has been obtained from the patient manager as described in 441—Chapter 88.

This rule is intended to implement Iowa Code section 249A.4.

441—79.12(249A) Advance directives. “Advance directive” means a written instruction, such as a living will or durable power of attorney for health care, recognized under state law and related to the provision of health care when the person is incapacitated. All hospitals, home health agencies, home health providers of waiver services, hospice programs, and health maintenance organizations (HMOs) participating in Medicaid shall establish policies and procedures with respect to all adults receiving medical care through the provider or organization to comply with state law regarding advance directives as follows:

79.12(1) A hospital at the time of a person's admission as an inpatient, a home health care provider in advance of a person's coming under the care of the provider, a hospice provider at the time of initial receipt of hospice care by a person, and a health maintenance organization at the time of enrollment of the person with the organization shall provide written information to each adult which explains the person's rights under state law to make decisions concerning medical care, including the right to accept or refuse medical or surgical treatment and the right to formulate advance directives, and the provider's policies regarding the implementation of these rights.

79.12(2) The provider or organization shall document in the person's medical record whether or not the person has executed an advance directive.

79.12(3) The provider or organization shall not condition the provision of care or otherwise discriminate against a person based on whether or not the person has executed an advance directive.

79.12(4) The provider or organization shall ensure compliance with requirements of state law regarding advance directives.

79.12(5) The provider or organization shall provide for education for staff and the community on issues concerning advance directives.

Nothing in this rule shall be construed to prohibit the application of a state law which allows for an objection on the basis of conscience for any provider or organization which as a matter of conscience cannot implement an advance directive.

This rule is intended to implement Iowa Code section 249A.4.

441—79.13(249A) Requirements for enrolled Medicaid providers supplying laboratory services. Medicaid enrolled entities providing laboratory services are subject to the provisions of the Clinical Laboratory Improvement Amendments of 1988 (CLIA), Public Law 100-578, and implementing federal regulations published at 42 CFR Part 493 as amended to December 29, 2000. Medicaid payment shall not be afforded for services provided by an enrolled Medicaid provider supplying laboratory services that fails to meet these requirements. For the purposes of this rule, laboratory services are defined as services to examine human specimens for the diagnosis, prevention or treatment of any disease or impairment of, or assessment of, the health of human beings.

This rule is intended to implement Iowa Code section 249A.4.

441—79.14(249A) Provider enrollment.

79.14(1) Application request. Iowa Medicaid providers other than managed care organizations and Medicaid fiscal agents shall begin the enrollment process by completing the appropriate application on the Iowa Medicaid enterprise Web site.

a. Providers of home- and community-based waiver services shall submit Form 470-2917, Medicaid HCBS Provider Application, at least 90 days before the planned service implementation date.

b. Providers enrolling as ordering or referring providers shall submit Form 470-5111, Iowa Medicaid Ordering/Referring Provider Enrollment Application.

c. All other providers shall submit Form 470-0254, Iowa Medicaid Provider Enrollment Application.

d. A nursing facility shall also complete the process set forth in 441—subrule 81.13(1).

e. An intermediate care facility for persons with an intellectual disability shall also complete the process set forth in 441—subrule 82.3(1).

79.14(2) Submittal of application. The provider shall submit the appropriate application forms, including the application fee, if required, to the Iowa Medicaid enterprise provider services unit by personal delivery, by e-mail, via online enrollment systems, or by mail to P.O. Box 36450, Des Moines, Iowa 50315.

a. The application shall include the provider's national provider identifier number or shall indicate that the provider is an atypical provider that is not issued a national provider identifier number.

b. With the application form, an assertive community treatment program shall submit Form 470-4842, Assertive Community Services (ACT) Provider Agreement Addendum, and agree to file with the department an annual report containing information to be used for rate setting, including:

(1) Data by practitioner on the utilization by Medicaid members of all the services included in assertive community treatment, and

(2) Cost information by practitioner type and by type of service actually delivered as part of assertive community treatment.

c. With the application form, or as a supplement to a previously submitted application, providers of health home services shall submit Form 470-5100, Health Home Provider Agreement.

d. Application fees.

(1) Providers who are enrolling or reenrolling in the Iowa Medicaid program shall submit an application fee with their application unless they are exempt as set forth in this paragraph.

(2) Fee amount. The application fee shall be in the amount prescribed by the Secretary of the U.S. Department of Health and Human Services (the Secretary) for the calendar year in which the application is submitted and in accordance with 42 U.S.C. 1395cc(j)(2)(C).

(3) Nonrefundable. The application fee is nonrefundable, except if submitted with one of the following:

1. A hardship exception request that is subsequently approved by the Secretary.

2. An application that is subsequently denied as a result of a temporary moratorium under 2013 Iowa Acts, Senate File 357, section 12.

3. An application or other transaction in which the application fee is not required.

(4) The process for enrolling or reenrolling a provider will not begin until the application fee has been received by the department or a hardship exception request has been approved by the Secretary.

(5) Exempt providers. The following providers shall not be required to submit an application fee:

1. Individual physicians or nonphysician practitioners.
2. Providers that are enrolled in Medicare, another state's Medicaid program or another state's children's health insurance program.

3. Providers that have paid the applicable application fee within 12 months of the date of application submission to a Medicare contractor or another state.

(6) All application fees collected shall be used for the costs associated with the screening procedures as described in subrule 79.14(4). Any unused portion of the application fees collected shall be returned to the federal government in accordance with 42 CFR § 455.460.

79.14(3) Program integrity information requirements.

a. All providers, including but not limited to managed care organizations and Medicaid fiscal agents, applying for participation in the Iowa Medicaid program must disclose all information required to be submitted pursuant to 42 CFR Part 455. In addition, all providers shall disclose any current, or previous, direct or indirect affiliation with a present or former Iowa Medicaid provider that:

(1) Has any uncollected debt owed to Medicaid or any other health care program funded by any governmental entity, including but not limited to the federal and state of Iowa governments;

(2) Has been or is subject to a payment suspension under a federally funded health care program;

(3) Has been excluded from participation under Medicaid, Medicare, or any other federally funded health care program;

(4) Has had its billing privileges denied or revoked;

(5) Has been administratively dissolved by the Iowa secretary of state, or similar action has been taken by a comparable agency in another state; or

(6) Shares a national provider identification (NPI) number or tax ID number with another provider that meets the criteria specified in subparagraph 79.14(3) "a" (1), (2), (3), (4), or (5).

b. The Iowa Medicaid enterprise may deny enrollment to a provider applicant or disenroll a current provider that has any affiliation as set forth in this rule if the department determines that the affiliation poses a risk of fraud, waste, or abuse. Such denial or disenrollment is appealable under 441—Chapter 7 but, notwithstanding any provision to the contrary in that chapter, the provider shall bear the burden to prove by clear and convincing evidence that the affiliation does not pose any risk of fraud, waste, or abuse. The Iowa Medicaid enterprise shall deny enrollment to or shall immediately disenroll any person that the Iowa Medicaid enterprise, Medicare, or any other state Medicaid program has ever terminated under rule 441—79.2(249A) or a similar provision and shall deny enrollment to any person presently suspended from participation, or who would be subject to a suspension, under paragraph 79.2(3) "c." Further, a person sanctioned under rule 441—79.2(249A) or a similar provision may not manage consumer choices option (CCO) funds for a member.

c. For purposes of this rule, the term "direct or indirect affiliation" includes but is not limited to relationships between individuals, business entities, or a combination of the two. The term includes but is not limited to direct or indirect business relationships that involve:

(1) A compensation arrangement;

(2) An ownership arrangement;

(3) Managerial authority over any member of the affiliation;

(4) The ability of one member of the affiliation to control or influence any other; or

(5) The ability of a third party to control or influence any member of the affiliation.

d. Notwithstanding any previous successful enrollment in the medical assistance program, the passing of any background check by the department or any other entity, or similar prior approval for participation as a provider in the medical assistance program, in whole or in part, disenrollment from the medical assistance program is mandatory when, in the case of a corporation or similar entity, 5 percent or more of the corporation or similar entity is owned, controlled, or directed by a person who (1) has within the last five years been listed on any dependent adult abuse registry, child abuse registry, or sex offender registry; (2) has pled guilty or nolo contendere to, or was convicted of, any crime punishable by a term of imprisonment greater than five years; (3) has, within the last five years, pled guilty or nolo contendere to, or was convicted of, any controlled substance offense; (4) has, within the last ten years,

pled guilty or nolo contendere to, or was convicted of, any crime involving an allegation of dishonesty punishable by a term of imprisonment greater than one year but not more than five years; or (5) within the last ten years, has on more than one occasion pled guilty or nolo contendere to, or was convicted of, any crime involving an allegation of dishonesty.

79.14(4) Screening procedures and requirements. Providers applying for participation in the Iowa Medicaid program shall be subject to the “limited,” “moderate,” or “high” categorical risk screening procedures and requirements in accordance with 42 CFR §455.450.

a. For the types of providers that are recognized as a provider under the Medicare program, the Iowa Medicaid enterprise shall use the same categorical risk screening procedures and requirements assigned to that provider type by Medicare pursuant to 42 CFR §424.518.

b. Provider types not assigned a screening level by the Medicare program shall be subject to the procedures of the “limited” risk screening level pursuant to 42 CFR §455.450.

c. Adjustment of risk level. The Iowa Medicaid enterprise shall adjust the categorical risk screening procedures and requirements from “limited” or “moderate” to “high” when any of the following occurs:

(1) The Iowa Medicaid enterprise imposes a payment suspension on a provider based on a credible allegation of fraud, waste, or abuse; the provider has an existing Medicaid overpayment; or within the previous ten years, the provider has been excluded by the Office of the Inspector General or another state’s Medicaid program; or

(2) The Iowa Medicaid enterprise or the Centers for Medicare and Medicaid Services in the previous six months lifted a temporary moratorium for the particular provider type, and a provider that was prevented from enrolling based on the moratorium applies for enrollment as a provider at any time within six months from the date the moratorium was lifted.

79.14(5) Notification. A provider shall be notified of the decision on the provider’s application within 30 calendar days of receipt by the Iowa Medicaid enterprise provider services unit of a complete and correct application with all required documents, including, but not limited to, if applicable, any application fees or screening results.

79.14(6) A provider that is not approved as the Medicaid provider type requested shall have the right to appeal under 441—Chapter 7.

79.14(7) Effective date of approval. An application shall be approved retroactive to the date requested by the provider or the date the provider meets the applicable participation criteria, whichever is later, not to exceed 12 months retroactive from the receipt of the application with all required documents by the Iowa Medicaid enterprise provider services unit.

79.14(8) A provider approved for certification as a Medicaid provider shall complete a provider participation agreement as required by rule 441—79.6(249A).

79.14(9) No payment shall be made to a provider for care or services provided prior to the effective date of the Iowa Medicaid enterprise’s approval of an application.

79.14(10) Payment rates dependent on the nature of the provider or the nature of the care or services provided shall be based on information on the application, together with information on claim forms, or on rates paid the provider prior to April 1, 1993.

79.14(11) An amendment to an application shall be submitted to the Iowa Medicaid enterprise provider services unit and shall be approved or denied within 30 calendar days. Approval of an amendment shall be retroactive to the date requested by the provider or the date the provider meets all applicable criteria, whichever is later, not to exceed 30 days prior to the receipt of the amendment by the Iowa Medicaid enterprise provider services unit. Denial of an amendment may be appealed under 441—Chapter 7.

79.14(12) A provider that has not submitted a claim in the last 24 months will be sent a notice asking if the provider wishes to continue participation. A provider that fails to reply to the notice within 30 calendar days of the date on the notice will be terminated as a provider. Providers that do not submit any claims in 48 months will be terminated as providers without further notification.

79.14(13) Report of changes. The provider shall inform the Iowa Medicaid enterprise of all pertinent changes to enrollment information within 35 days of the change. Pertinent changes include, but are not

limited to, changes to the business entity name, individual provider name, tax identification number, mailing address, telephone number, or any information required to be disclosed by subrule 79.14(3).

a. When a provider reports false, incomplete, or misleading information on any application or reapplication, or fails to provide current information within the 35-day period, the Iowa Medicaid enterprise may immediately terminate the provider's Medicaid enrollment. The termination may be appealed under 441—Chapter 7. Such termination remains in effect notwithstanding any pending appeal.

b. When the department incurs an informational tax-reporting fine or is required to repay the federal share of medical assistance paid to the provider because a provider submitted inaccurate information or failed to submit changes to the Iowa Medicaid enterprise in a timely manner, the fine or repayment shall be the responsibility of the individual provider to the extent that the fine or repayment relates to or arises out of the provider's failure to keep all provider information current.

(1) The provider shall remit the amount of the fine or repayment to the department within 30 days of notification by the department that the fine has been imposed.

(2) Payment of the fine or repayment may be appealed under 441—Chapter 7.

79.14(14) Provider termination or denial of enrollment. The Iowa Medicaid enterprise must terminate or deny any provider enrollment when the provider has violated any requirements identified in 42 CFR §455.416.

79.14(15) Temporary moratoria. The Iowa Medicaid enterprise must impose any temporary moratorium pursuant to 2013 Iowa Acts, Senate File 357, section 12.

79.14(16) Provider revalidation. Providers are required to complete the application process and screening requirements as detailed in this rule every five years.

79.14(17) Recoupment. A provider is strictly liable for any failure to disclose the information required by subrule 79.14(3) or any failure to report a change required by subrule 79.14(13). The department shall recoup as incorrectly paid all funds paid to the provider before a complete disclosure or report of change was made. The department shall also recoup as incorrectly paid all funds to any provider that billed the Iowa Medicaid enterprise while the provider was administratively dissolved by the Iowa secretary of state or comparable agency of another state, even if the provider subsequently obtains a retroactive reinstatement from the Iowa secretary of state or similar action was taken against the provider by a comparable agency of another state.

This rule is intended to implement Iowa Code section 249A.4.

[**ARC 9440B**, IAB 4/6/11, effective 4/1/11; **ARC 0198C**, IAB 7/11/12, effective 7/1/12; **ARC 0580C**, IAB 2/6/13, effective 4/1/13; **ARC 1153C**, IAB 10/30/13, effective 1/1/14; **ARC 1695C**, IAB 10/29/14, effective 1/1/15]

441—79.15(249A) Education about false claims recovery. The provisions in this rule apply to any entity that has received medical assistance payments totaling at least \$5 million during a federal fiscal year (ending on September 30). For entities whose payments reach this threshold, compliance with this rule is a condition of receiving payments under the medical assistance program during the following calendar year.

79.15(1) Policy requirements. Any entity whose medical assistance payments meet the threshold shall:

a. Establish written policies for all employees of the entity and for all employees of any contractor or agent of the entity, including management, which provide detailed information about:

(1) The False Claims Act established under Title 31, United States Code, Sections 3729 through 3733;

(2) Administrative remedies for false claims and statements established under Title 31, United States Code, Chapter 38;

(3) Any state laws pertaining to civil or criminal penalties for false claims and statements;

(4) Whistle blower protections under the laws described in subparagraphs (1) to (3) with respect to the role of these laws in preventing and detecting fraud, waste, and abuse in federal health care programs, as defined in Title 42, United States Code, Section 1320a-7b(f); and

(5) The entity's policies and procedures for detecting and preventing fraud, waste, and abuse.

b. Include in any employee handbook a specific discussion of:

- (1) The laws described in paragraph 79.15(1) “a”;
- (2) The rights of employees to be protected as whistle blowers; and
- (3) The entity’s policies and procedures for detecting and preventing fraud, waste, and abuse.

79.15(2) Reporting requirements.

a. Any entity whose medical assistance payments meet the specified threshold during a federal fiscal year shall provide the following information to the Iowa Medicaid enterprise by the following December 31:

- (1) The name, address, and national provider identification numbers under which the entity receives payment;
- (2) Copies of written or electronic policies that meet the requirements of subrule 79.15(1); and
- (3) A written description of how the policies are made available and disseminated to all employees of the entity and to all employees of any contractor or agent of the entity.

b. The information may be provided by:

- (1) Mailing the information to the IME Program Integrity Unit, P.O. Box 36390, Des Moines, Iowa 50315; or
- (2) Faxing the information to (515)725-1354.

79.15(3) Enforcement. Any entity that fails to comply with the requirements of this rule shall be subject to sanction under rule 441—79.2(249A), including probation, suspension or withholding of payments, and suspension or termination from participation in the medical assistance program.

This rule is intended to implement Iowa Code section 249A.4 and Public Law 109-171, Section 6032.

[ARC 9440B, IAB 4/6/11, effective 4/1/11]

441—79.16(249A) Electronic health record incentive program. The department has elected to participate in the electronic health record (EHR) incentive program authorized under Section 4201 of the American Recovery and Reinvestment Act of 2009 (ARRA), Public Law No. 111-5. The electronic health record incentive program provides incentive payments to eligible hospitals and professionals participating in the Iowa Medicaid program that adopt and successfully demonstrate meaningful use of certified electronic health record technology.

79.16(1) State elections. In addition to the statutory provisions in ARRA Section 4201, the electronic health record incentive program is governed by federal regulations at 42 CFR Part 495 as amended to September 4, 2012. In compliance with the requirements of federal law, the department establishes the following state options under the Iowa electronic health record incentive program:

a. For purposes of the term “hospital-based eligible professional (EP)” as set forth in 42 CFR Section 495.4 as amended to September 4, 2012, the department elects the calendar year preceding the payment year as the period used to gather data to determine whether or not an eligible professional is “hospital-based” for purposes of the regulation.

b. For purposes of calculating patient volume as required by 42 CFR Section 495.306 as amended to September 4, 2012, the department has elected that eligible providers may use either:

- (1) The patient encounter methodology found in 42 CFR Section 495.306(c) as amended to September 4, 2012, or
- (2) The patient panel methodology found in 42 CFR Section 495.306(d) as amended to September 4, 2012.

c. For purposes of 42 CFR Section 495.310(g)(1)(i)(B) as amended to September 4, 2012, the “12-month period selected by the state” shall mean the hospital fiscal year.

d. For purposes of 42 CFR Section 495.310(g)(2)(i) as amended to September 4, 2012, the “12-month period selected by the state” shall mean the hospital fiscal year.

79.16(2) Eligible providers. To be deemed an “eligible provider” for the electronic health record incentive program, a provider must satisfy the applicable criterion in each paragraph of this subrule:

- a.* The provider must be currently enrolled as an Iowa Medicaid provider.
- b.* The provider must be one of the following:

- (1) An eligible professional, listed as:
 1. A physician,
 2. A dentist,
 3. A certified nurse midwife,
 4. A nurse practitioner, or
 5. A physician assistant practicing in a federally qualified health center or a rural health clinic when the physician assistant is the primary provider, clinical or medical director, or owner of the site.
- (2) An acute care hospital, as defined in 42 CFR Section 495.302 as amended to September 4, 2012.
- (3) A children's hospital, as defined in 42 CFR Section 495.302 as amended to September 4, 2012.
- c. For the year for which the provider is applying for an incentive payment:
 - (1) An acute care hospital must have 10 percent Medicaid patient volume.
 - (2) An eligible professional must have at least 30 percent of the professional's patient volume enrolled in Medicaid, except that:

1. A pediatrician must have at least 20 percent Medicaid patient volume. For purposes of this subrule, a "pediatrician" is a physician who is board-certified in pediatrics by the American Board of Pediatrics or the American Osteopathic Board of Pediatrics or who is eligible for board certification.

2. When a professional has at least 50 percent of patient encounters in a federally qualified health center or rural health clinic, patients who were furnished services either at no cost or at a reduced cost based on a sliding scale or ability to pay, patients covered by the HAWK-I program, and Medicaid members may be counted to meet the 30 percent threshold.

79.16(3) Application and agreement. Any eligible provider that intends to participate in the Iowa electronic health record incentive program must declare the intent to participate by registering with the CMS Registration and Attestation Web site, as developed by the Centers for Medicare and Medicaid Services (CMS). CMS will notify the department of an eligible provider's application for the incentive payment.

- a. Upon receipt of an application for participation in the program, the department will contact the applicant with instructions for accessing the Iowa EHR Medicaid incentive payment administration Web site at www.imeincentives.com. The applicant shall use the Web site to:

- (1) Attest to the applicant's qualifications to receive the incentive payment, and
 - (2) Digitally sign Form 470-4976, Iowa Electronic Health Record Incentive Program Provider Agreement.

- b. For the second year of participation, eligible providers must submit meaningful use and clinical quality measures to the department, either through attestation or electronically as required by the department.

- c. The department shall verify the applicant's eligibility, including patient volume and practice type, and the applicant's use of certified electronic health record technology.

79.16(4) Payment. The department shall issue the incentive payment only after confirming that all eligibility and performance criteria have been satisfied. Payments will be processed and paid to the tax identification number designated by the applicant. The department will communicate the payment or denial of payment to the CMS Registration and Attestation Web site.

- a. The primary communication channel from the department to the provider will be the Iowa EHR Medicaid incentive payment administration Web site. If the department finds that the applicant is ineligible or has failed to achieve the criteria necessary for the payment, the department shall notify the provider through the Web site. Providers shall access the Web site to determine the status of their payment, including whether the department denied payment and the reason for the denial.

- b. Providers must retain records supporting their eligibility for the incentive payment for a minimum of six years. The department will select providers for audit after issuance of an incentive payment. Incentive recipients shall cooperate with the department by providing proof of:

- (1) Eligibility,
 - (2) Purchase of certified electronic health record technology, and
 - (3) Meaningful use of electronic health record technology.

79.16(5) *Administrative appeal.* Any eligible provider or any provider that claims to be an eligible provider and who has been subject to an adverse action related to the Iowa electronic health record incentive program may seek review of the department's action pursuant to 441—Chapter 7. Appealable issues include:

- a. Provider eligibility determination.
- b. Incentive payments.
- c. Demonstration of adopting, implementing, upgrading and meaningful use of technology.

This rule is intended to implement Iowa Code section 249A.4 and Public Law No. 111-5.

[ARC 9254B, IAB 12/1/10, effective 1/1/11; ARC 9531B, IAB 6/1/11, effective 5/12/11; ARC 0824C, IAB 7/10/13, effective 9/1/13]

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⁰ Two or more ARCs

¹ Effective date of 79.1(2) and 79.1(5) "t" delayed 70 days by the Administrative Rules Review Committee at its January 1988, meeting.

² Effective date of 4/1/90 delayed 70 days by the Administrative Rules Review Committee at its March 12, 1990, meeting; delay lifted by this Committee, effective May 11, 1990.

³ Effective date of subrule 79.1(13) delayed until adjournment of the 1992 Sessions of the General Assembly by the Administrative Rules Review Committee at its meeting held July 12, 1991.

- ⁴ Effective date of 3/1/92 delayed until adjournment of the 1992 General Assembly by the Administrative Rules Review Committee at its meeting held February 3, 1992.
- ⁵ At a special meeting held January 24, 2002, the Administrative Rules Review Committee voted to delay until adjournment of the 2002 Session of the General Assembly the effective date of amendments published in the February 6, 2002, Iowa Administrative Bulletin as **ARC 1365B**.
- ⁶ Effective date of October 1, 2002, delayed 70 days by the Administrative Rules Review Committee at its meeting held September 10, 2002. At its meeting held November 19, 2002, the Committee voted to delay the effective date until adjournment of the 2003 Session of the General Assembly.
- ⁷ July 1, 2009, effective date of amendments to 79.1(1) "d," 79.1(2), and 79.1(24) "a"(1) delayed 70 days by the Administrative Rules Review Committee at a special meeting held June 25, 2009.
- ⁸ See HJR 2008 of 2012 Session of the Eighty-fourth General Assembly regarding nullification of amendment to 79.1(7) "b" (ARC 9959B, IAB 1/11/12).

TITLE IX
WORK INCENTIVE DEMONSTRATION
CHAPTER 93
PROMISE JOBS PROGRAM
[Prior to 7/1/89, see 441—Chapters 55, 59 and 90]

PREAMBLE

This chapter implements the promoting independence and self-sufficiency through employment, job opportunities, and basic skills (PROMISE JOBS) program. The PROMISE JOBS program is designed to assist family investment program (FIP) recipients to become self-sufficient. Unless exempt, each FIP applicant must develop a family investment agreement (FIA) that outlines steps the applicant will take to leave public assistance and must cooperate with the terms of the agreement as a condition for receiving FIP as directed in Iowa Code chapter 239B. Rules regarding FIP eligibility requirements, including participation in the PROMISE JOBS program, are found in 441—Chapter 41.

The PROMISE JOBS program also implements the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA), Title I, “Block Grants for Temporary Assistance for Needy Families (TANF),” which was reauthorized on February 8, 2006, through the Deficit Reduction Act of 2005, Public Law 109-171.

441—93.1(239B) Definitions.

“*Applicant*” means a child for whom assistance is being requested under the family investment program, any parent living in the home with the child, and any nonparental relative as defined in 441—subrule 41.22(3) who is requesting assistance for the child.

“*FaDSS*” means the family development and self-sufficiency program operated under 441—Chapter 165, which provides services to families at risk of long-term welfare dependency.

“*Family investment agreement*” or “*FIA*” means the agreement developed with a participant in accordance with Iowa Code section 239B.8.

“*FIA-responsible person*” means any member of the FIP applicant family unless exempt as described at 441—subrule 41.24(2). See subrule 93.4(2) for more information.

“*FIP*” means the family investment program authorized in Iowa Code chapter 239B.

“*Limited benefit plan*” or “*LBP*” means a period of time in which a participant or member of a participant’s family is either ineligible for any assistance under the family investment program or eligible for reduced assistance only in accordance with Iowa Code section 239B.9.

“*Needy specified relative*” means a nonparental specified relative as defined in 441—subrule 41.22(3) who meets all the eligibility requirements to be included in the family investment program.

“*Participant*” for purposes of the PROMISE JOBS program means a person who has signed an FIA and is approved to receive FIP benefits, a parent or relative living in the home of a child approved to receive FIP benefits, or a person reconsidering a subsequent limited benefit plan.

“*PROMISE JOBS program*” means the promoting independence and self-sufficiency through employment, job opportunities, and basic skills program created in Iowa Code section 239B.17.

441—93.2(239B) Program administration. The department of human services shall administer an employment and training program known as PROMISE JOBS. To the extent compatible with resources available, the department’s bureau of refugee services shall provide PROMISE JOBS services to persons who entered the United States with refugee status until those persons obtain United States citizenship.

93.2(1) Availability of service. PROMISE JOBS services shall include, but are not limited to, those listed in paragraph 93.4(4)“b.”

a. The program shall be available statewide. If the department of human services determines that sufficient funds are not available to offer services on location in each county, the department shall prioritize the availability of services to those counties having the largest FIP populations.

b. Because of state and federal budgetary limitations, federal mandatory work requirements, requirements for minimum participation rates, and other TANF requirements imposed on the PROMISE JOBS program, the department of human services shall have the administrative authority to:

- (1) Determine agency and geographical breakdowns for service;
- (2) Designate specific groups for priority services; and
- (3) Designate specific PROMISE JOBS components or supportive service levels for a waiting list.

93.2(2) *Contracts with provider agencies.* The department of human services may contract with the department of workforce development, the department of economic development, or other appropriate entity to provide PROMISE JOBS services and case management of those services.

a. Reimbursement for services. The provider agency shall receive financial reimbursement as specified in contracts negotiated with each agency. Contracts shall also specify in detail the expenses that are not eligible for reimbursement.

b. Record keeping. All PROMISE JOBS agencies shall maintain PROMISE JOBS participant case files and records for at least three years, in either paper or electronic format. Records shall be maintained for longer than three years if any litigation, audit, or claim is started and not resolved during that period. In these instances, the records must be retained for three years after the litigation, audit, or claim is resolved. Case files must be disposed of in accordance with applicable federal requirements pertaining to confidentiality.

c. Confidentiality. The departments of education, workforce development, economic development, and human rights, local education agencies, and all subcontractor provider agencies shall safeguard participant information in conformance with Iowa Code section 217.30. The department of human services and the PROMISE JOBS provider agencies may disclose participant information to other state agencies or to any other entity when that agency or entity must have that information in order to provide services to PROMISE JOBS participants that have been determined to be necessary for successful participation in PROMISE JOBS.

[ARC 1694C, IAB 10/29/14, effective 1/1/15]

441—93.3(239B) Registration and referral.

93.3(1) *Registration for PROMISE JOBS.* Unless the department of human services determines a person is exempt as specified in 441—subrule 41.24(2), an application for FIP assistance constitutes a registration for the PROMISE JOBS program and acceptance of the requirement to enter into an FIA for all members of the FIP case and all other persons responsible for the FIA as specified at rule 441—41.24(239B).

93.3(2) *Referral.* The department of human services shall refer all FIA-responsible persons from FIP applicant and participant households to PROMISE JOBS pursuant to 441—subrule 41.24(4).

93.3(3) *Initial appointment.*

a. FIP applicants. FIP applicants, including those who are in a limited benefit plan, shall be offered an appointment with the PROMISE JOBS provider agency for assessment and FIA development at the earliest available time. The provider agency shall make sufficient appointment times available to allow the applicant to be scheduled no later than ten calendar days after the date of the notice that FIA responsibility has begun, as required by rule 441—93.4(239B) and 441—paragraphs 41.24(1)“c,” 41.24(1)“d,” and 41.24(10)“g.”

b. Exempt status change. Persons who become FIA-responsible while receiving FIP shall initiate PROMISE JOBS orientation and FIA development by contacting the appropriate PROMISE JOBS office to schedule an appointment within ten calendar days of the mailing date of the letter explaining that exempt status has been lost and FIA responsibility has begun, as required by 441—subrule 41.24(5). If the person fails to schedule an appointment or fails to appear for an appointment, PROMISE JOBS shall send one written reminder that informs the person that those who do not develop a family investment agreement shall enter into a limited benefit plan. If the person fails to schedule an appointment within ten calendar days of the reminder letter or fails to appear for an appointment scheduled after the reminder is sent, the person shall enter into a limited benefit plan as described at 441—paragraph 41.24(8)“c.”

93.3(4) Orientation. Every person referred to PROMISE JOBS shall receive orientation services. PROMISE JOBS workers shall provide FIA orientation if not previously provided by the department of human services.

a. During orientation, each applicant shall receive a full explanation of:

- (1) The advantages of employment under the family investment program (FIP), including information on earned income tax credits;
- (2) Services available under PROMISE JOBS;
- (3) Participant rights and responsibilities under the FIA and PROMISE JOBS;
- (4) The limited benefit plan as described at 441—subrule 41.24(8);
- (5) The benefits of cooperation with the child support recovery unit;
- (6) Other programs available through the department of human services, specifically the transitional Medicaid and child care assistance programs; and
- (7) The availability of family planning counseling services in the area and the financial implications of newly born children on the participant's family.

b. Each applicant shall sign Form 470-3104, Your FIA Rights and Responsibilities, acknowledging that information described in paragraph “a” of this subrule has been provided.

93.3(5) Initial meeting. The PROMISE JOBS worker shall meet with each referred person, or with the family if another parent or a child is also referred to PROMISE JOBS, to:

- a.* Determine participation activities,
- b.* Establish expenses and a schedule for supportive payments, and
- c.* Discuss child care needs.

93.3(6) Workforce development registration. Each applicant is required to complete a current workforce development registration form as described at 877—subrule 8.2(3) when requested by the PROMISE JOBS worker.

[ARC 1146C, IAB 10/30/13, effective 1/1/14]

441—93.4(239B) The family investment agreement (FIA). The family investment agreement (FIA) is the condition of and basis for PROMISE JOBS services and is an eligibility requirement for the family investment program as specified in rule 441—41.24(239B).

93.4(1) Development. An initial FIA shall be developed during the orientation and assessment process through discussion between the FIA-responsible person and the PROMISE JOBS worker. For the FIA to be considered completed, Form 470-3095, Family Investment Agreement, and Form 470-3096, FIA Steps to Achieve Self-Sufficiency, shall be signed by all of the following:

- a.* The FIA-responsible person or persons.
- b.* Other family members who are referred to PROMISE JOBS.
- c.* The PROMISE JOBS worker.
- d.* The PROMISE JOBS supervisor.

93.4(2) FIA-responsible persons. All members of the FIP applicant family shall develop and sign an FIA, unless exempt as described at 441—subrule 41.24(2). When an FIA-responsible person is incompetent or incapacitated, someone acting responsibly on that person's behalf may participate in the interview. Responsibility for carrying out the steps of the FIA ends at the point that FIP assistance is not provided to the participant or when a participant becomes exempt.

a. Parents. All parents who are not exempt from PROMISE JOBS shall be responsible for signing and carrying out the activities of the FIA. Parents of any age are exempt only if they are receiving Supplemental Security Income (SSI) or they do not meet citizenship requirements. When the FIP eligible group includes a minor parent living with one or both parents or a needy specified relative who receives FIP, as described at 441—subparagraph 41.28(2)“b”(2), and none is exempt from PROMISE JOBS participation, each parent or needy specified relative is responsible for a separate FIA.

b. Teens. Persons aged 16 to 19 shall be responsible for signing and carrying out the activities of the FIA unless they are receiving Supplemental Security Income (SSI) or they attend school full-time.

(1) When the FIP-eligible group includes one or both parents or a needy specified relative and a child or children and none is exempt from PROMISE JOBS participation, all shall be asked to sign one

FIA with the family and to carry out the activities of that FIA rather than signing separate FIAs. Copies of the FIA shall be placed in each individual case file.

(2) When the FIP-eligible group includes one or both parents or a needy specified relative who is exempt from PROMISE JOBS participation and a child or children who are not exempt, each child is responsible for completing a separate FIA.

(3) A minor nonparental specified relative who is not exempt and whose needs are included in the FIP grant shall be responsible for signing and carrying out the activities of the FIA.

c. Other adults. All other adults who are not exempt and whose needs are included in the FIP grant shall be responsible for signing and carrying out the activities of the FIA.

93.4(3) FIA content. The FIA shall include the goals of the family for achieving self-sufficiency and shall establish a time frame with a specific ending date, during which the family expects to become self-sufficient and after which FIP benefits will be terminated. For individuals and families with acknowledged barriers, one or more incremental FIAs may be written.

a. All FIAs shall:

(1) Outline the expectations of the PROMISE JOBS program and of the family;

(2) Clearly establish interim goals and FIA activities necessary to reach long-term goals and self-sufficiency;

(3) Identify barriers to participation so that the FIA may include a plan, appropriate referrals, and supportive services necessary to eliminate or manage the barriers;

(4) Stipulate specific services to be provided by the PROMISE JOBS program, including child care assistance, transportation assistance, family development services, and other supportive services;

(5) Include the participant's responsibility to provide verification of hours of participation, and how and when the verification shall be submitted;

(6) Record a participant's response to the option of referral for family planning counseling as described at subrule 93.9(3).

b. Plans from other agencies. The FIA may incorporate a self-sufficiency plan that the family has developed with another agency or person, such as, but not limited to, Head Start, public housing authorities, child welfare workers, vocational rehabilitation, and FaDSS grantees, subject to the following requirements:

(1) The participant shall authorize PROMISE JOBS to obtain the self-sufficiency plan and to arrange coordination with the manager of the self-sufficiency plan by signing Form 470-0429, Consent to Obtain and Release Information.

(2) The self-sufficiency plan may be included in the participant's FIA if the self-sufficiency plan meets the requirements of this chapter and is deemed by the PROMISE JOBS worker to be appropriate to the family circumstances.

93.4(4) Participation requirements. The FIA shall require the FIA-responsible persons and family members who are referred to PROMISE JOBS to choose participation in one or more activities as described in this subrule.

a. Goals. It is expected that employment leading to economic self-sufficiency is the eventual goal of the FIA.

(1) To the maximum extent possible, the FIA shall reflect the goals of the family, subject to program rules; funding; the capability, experience, and aptitudes of family members; and the potential market for the job skills currently possessed or to be developed.

(2) The program goal for all participants is to be involved in PROMISE JOBS activities on a full-time basis unless barriers prohibit this level of involvement. "Full-time" is considered as an average of at least 30 hours per week. Exceptions to full-time involvement are identified in rule 441—93.14(239B) and subrule 93.4(5).

b. Activities. Except as specified in paragraph 93.4(4) "c," PROMISE JOBS activities may include, but are not limited to, any combination of the following activities:

(1) Orientation as described in subrule 93.3(4).

(2) Assessment as described in rule 441—93.5(239B).

(3) Job readiness activities, including job club, individual job search, workplace essentials training, mental health treatment, substance abuse treatment, or other rehabilitative activities, as described in rule 441—93.6(239B).

(4) Work activities, including part-time or full-time employment, self-employment, on-the-job training, work experience, or unpaid community service as described in rule 441—93.7(239B).

(5) Educational activities, including high school completion, high school equivalency diploma (HSED) certification, adult basic education (ABE), English as a second language (ESL) training, vocational training, or postsecondary training up to and including a baccalaureate degree, as described in rule 441—93.8(239B).

(6) Parenting skills training as described in subrule 93.9(1).

(7) Participation in the family development and self-sufficiency program (FaDSS) or other family development programs as described in subrule 93.9(2).

(8) Referral for family planning counseling as described in subrule 93.9(3).

(9) Services provided by other agencies.

c. FIA activities for participants aged 16 to 19. Development of FIA activities shall follow these guidelines for participants aged 16 to 19.

(1) Participants aged 16 to 19 who are not parents and who have not completed high school shall be strongly encouraged to participate in educational activities to obtain a high school diploma or the equivalent. A high school education is recognized as important to achieving self-sufficiency. Participants shall be given information on the earning power of people with a high school education compared to those who do not so that participants are able to make an informed choice. If high school or high school equivalency completion is not included in a teenager's FIA, other FIA activities shall be required. High school or high school equivalency completion shall be proposed and reconsidered at the next FIA review.

(2) Parents under the age of 18 who are not married and who have not completed high school shall be expected to use enrollment or continued attendance in high school or involvement in a high school equivalency program as a first step in the FIA, except when the parent is deemed incapable of participating in these activities by the local education agency.

(3) Parents aged 19 and younger shall include parenting skills training as described at subrule 93.9(1) in their FIA or the case file shall include documentation that this requirement has been fulfilled.

(4) Unmarried parents aged 17 and younger who do not live with a parent or legal guardian shall include FaDSS, as described at 441—Chapter 165, or other family development services, as described in subrule 93.9(2), in the FIA. The FaDSS or other family development services shall continue after the parent reaches the age of 18 only when the participant and the family development worker believe that the services are needed for the family to reach self-sufficiency.

d. Waiting lists. The department of human services reserves the authority to prioritize services to FIP applicants and participants in the order that best fits the needs of FIP applicants and recipients and of the PROMISE JOBS program. Participants who are placed on a waiting list for a PROMISE JOBS component shall include other appropriate activities in the FIA while waiting unless family circumstances indicate otherwise.

(1) Persons shall be removed from these waiting lists and placed in components at the discretion of state-level PROMISE JOBS administrators in order to help participants achieve self-sufficiency in the shortest possible time, meet budgetary limitations, enable participants to make maximum use of other programs, fulfill the federal minimum participation rate requirements, and meet other TANF requirements.

(2) Persons who were enrolled in approved postsecondary training at the time of FIP cancellation shall not be placed on a postsecondary training waiting list if the participant is still satisfactorily participating in approvable training at the time that FIP eligibility is regained.

e. Unavailability of funding. If funding for the PROMISE JOBS activities included in a participant's FIA or required supportive payments are not available, the participant's FIA shall be renegotiated to include different activities.

93.4(5) Barriers to participation. Problems with participation of a permanent or long-term nature shall be considered barriers to participation and shall be identified in the FIA as issues to be resolved or managed so that maximum participation can result.

a. Barriers defined. Barriers to participation shall include, but not be limited to, the following:

(1) Child or adult care needed before a person can participate or take a job is not available. Participants are not required to do any activity unless suitable child or adult care has been arranged.

(2) Lack of transportation.

(3) Substance addiction.

(4) Sexual or domestic abuse history.

(5) Overwhelming family stress.

(6) Physical or cognitive disability or mental illness.

b. Inclusion in FIA.

(1) When barriers are identified during assessment, removal or management of the barrier shall be part of the FIA from the beginning.

(2) When barriers are revealed by the applicant or participant during the FIA development or are identified by problems that develop after the FIA is signed, the FIA shall be renegotiated and amended to provide for removal or management of the barriers.

(3) In limited instances where special-needs care for a child or adult is not available, it may be most practical for the participant to develop the FIA to identify providing the care as part of the FIA.

c. Cooperation with removing or managing barriers.

(1) Applicants. An FIA-responsible applicant who chooses not to cooperate in removing or managing barriers to participation identified during FIA development shall be denied FIP.

(2) Participants. A participant who chooses not to cooperate in removing or managing identified barriers to participation shall be considered to have chosen the limited benefit plan. If the participant claims a cognitive or physical disability or mental illness that is expected to last for more than 12 consecutive months, the participant is required to apply for Social Security Disability and Supplemental Security Income benefits. When the participant refuses to apply for those benefits, the FIP household is ineligible for FIP as described at 441—subrule 41.27(1), and the limited benefit plan does not apply.

93.4(6) Failure to complete an FIA.

a. FIP applicants. An applicant's failure to develop or sign an FIA shall result in denial of the family's application for FIP assistance, as described at 441—paragraphs 41.24(4) "a," "b" and "c."

b. FIP participants. FIP participants who choose not to enter into an FIA or who choose not to continue its activities after signing an FIA shall enter into the limited benefit plan (LBP) as described at 441—subrule 41.24(8).

93.4(7) Progress reviews. The PROMISE JOBS worker shall review all FIAs at least once every six months. Progress reviews do not have to be face-to-face interviews but must include verbal contact with and input from at least one family member. FIA goals, Form 470-3096, FIA Steps for Achieving Self-Sufficiency, and, if appropriate, the needs for child care, transportation, and other supports shall be reviewed for continued appropriateness.

93.4(8) Renegotiation.

a. The FIA shall be renegotiated to reflect a new plan for self-sufficiency if:

(1) The participant has participated satisfactorily in the current FIA activities but is not self-sufficient by the end date specified in the FIA; or

(2) The participant demonstrates effort in carrying out the steps of the FIA but is unable to participate satisfactorily in the current FIA activities due to a barrier as described at subrule 93.4(5); or

(3) The participant's circumstances change to such an extent that the current FIA activities are no longer appropriate.

b. Participants who choose not to cooperate in the renegotiation process when requested by PROMISE JOBS shall be considered to have chosen the limited benefit plan.

93.4(9) Reinstatement. When a participant who has signed an FIA loses FIP eligibility and has not become exempt from PROMISE JOBS at the time of FIP reapplication, the contents of the original FIA and the participant's responsibility for carrying out the steps of that FIA may be reinstated when the steps

of the FIA fit the family's current circumstances. The FIA shall be renegotiated and amended if needed to accommodate changed family circumstances.

[ARC 1146C, IAB 10/30/13, effective 1/1/14; ARC 1694C, IAB 10/29/14, effective 1/1/15]

441—93.5(239B) Assessment. The purpose of assessment is to provide an evaluation of the FIP applicant or participant family that furnishes a basis for the PROMISE JOBS worker to determine: (1) family members' employability and educational potential, so that participants can make well-informed choices; and (2) the services that will be needed for the family to achieve self-sufficiency, so that the worker can provide appropriate guidance.

93.5(1) Initial assessment. All persons referred to PROMISE JOBS shall complete an initial assessment, which shall be used to develop the initial FIA. The PROMISE JOBS worker shall meet individually with FIA-responsible persons who are referred to PROMISE JOBS to develop the FIA.

a. Self-assessment. The participant may either fill out Form 470-0806, Self-Assessment, before the meeting or fill the form out during the meeting with assistance from the PROMISE JOBS worker. The results from self-assessment shall be used to assist in identifying the applicant's needs.

b. Scope of initial assessment. The initial assessment meeting, at a minimum, shall review the family's financial situation, family profile and goals, employment background, educational background, housing needs, child care needs, transportation needs, health care needs, family-size assessment and the participant's wishes regarding referral to family planning counseling, and other barriers which may require referral to entities other than PROMISE JOBS for services.

93.5(2) Additional assessments. Additional assessments may include, but are not limited to, literacy and aptitude testing, educational level and basic skills assessment, evaluation of job interests or job skills, occupation-specific assessment or testing, or an evaluation of past pertinent information. An additional assessment may be used by mutual agreement between the PROMISE JOBS worker and the participant as a tool and to help explore possible FIA development. For a specific additional assessment to be required, completion of the assessment must be specified in the FIA.

a. Additional information on applicants. If information identified during the initial assessment indicates that further information is needed to help the participant and PROMISE JOBS worker identify appropriate FIA activities and level of involvement, the applicant shall complete additional assessments as determined by the PROMISE JOBS worker. Completion of this assessment may be the first step in the initial FIA.

b. Medical examination. The PROMISE JOBS worker may require a person to complete a medical examination before including a particular PROMISE JOBS activity in the FIA when a participant specifies or exhibits any condition that might jeopardize successful participation in the program. The worker shall ask the health practitioner to indicate to the best of the practitioner's knowledge whether the person is capable of completing the FIA activity or continuing with appropriate employment.

c. Rehabilitation assessments. At any time during the assessment process or as more information is revealed, a referral may be made for professional assessments in physical health, mental health, substance abuse, or other rehabilitative services.

d. Additional information on participants. Assessments may be completed or redone at any time throughout the development and duration of the FIA if the information is needed to help the participant and the PROMISE JOBS worker make decisions concerning the type or level of the participant's involvement in PROMISE JOBS activities.

93.5(3) Postsecondary educational evaluation. Participants who wish to include postsecondary education in their FIA shall complete an educational evaluation to determine the likelihood of success.

a. Request for education resulting in a vocational certificate or certificate of completion. Vocational certificate or certification of completion training programs offer short-term training in a specific vocational area. Examples include, but are not limited to: nurse aid certification, training to receive a commercial driver's license, training in information technology, health care services, and child care services. The PROMISE JOBS worker shall determine the likelihood of success using the following types of tools or information:

- (1) A review of information from past training situations,
- (2) Past job performance in comparable positions,
- (3) Basic skills tests,
- (4) Career-specific assessments,
- (5) A specific standardized test, or
- (6) Other key historical information.

b. Request for education resulting in an associate or baccalaureate degree. The PROMISE JOBS worker shall determine the likelihood of academic success through an educational evaluation. The evaluation may include use of the following types of tools or information:

- (1) Standardized assessments in reading comprehension, math, and writing skills, such as GATB (General Aptitude Test Battery), Kuder Skills Assessment, or CASA (Comprehensive Adult Student Assessment) system;
- (2) Occupation-specific skills assessments;
- (3) Interest inventories;
- (4) Current or past grades; and
- (5) Other pertinent historical information.

c. Documenting educational evaluation results. When a participant has requested education to be included in the FIA, the PROMISE JOBS worker shall document:

- (1) What formal assessments were completed, if any, and what the results were;
- (2) What other information was reviewed;
- (3) How the evaluation information was used by the PROMISE JOBS worker in either approving or denying the inclusion of education in the participant's FIA; and
- (4) Whether the request is approved or denied. If the request is denied, PROMISE JOBS shall issue Form 470-0602, Notice of Decision: Services, to the participant as required in paragraph 93.10(1) "b."

93.5(4) *Substituting or supplementing an assessment.*

a. Substituting assessment information. If the FIA-responsible person's mental status, physical status, and life situation have not changed significantly, comparable assessment information completed with another agency or person within the past two years may be used instead of performing new assessments.

(1) Examples of agencies or persons that may complete comparable assessment information include, but are not limited to, the department of workforce development, Head Start, public housing authorities, child welfare workers, vocational rehabilitation services, an educational institution or testing service, or family development services.

(2) The FIA-responsible person may authorize PROMISE JOBS to obtain these assessment results by signing Form 470-0429, Consent to Obtain and Release Information.

b. Supplementing assessment information. In order to ensure that the family investment agreement activities do not conflict with any case plans that have already been established for the family, the FIA-responsible person may:

- (1) Supplement assessment information, and
- (2) Establish communication between the PROMISE JOBS worker and other agencies or persons.

c. Use of key historical information. When key historical information, such as a review of the participant's job history or past training outcomes, relays a clear picture of the participant's skills and abilities, a formal, standardized educational assessment may not be needed.

(1) If a participant is currently enrolled in or has been enrolled in comparable training or an academic program in the past two years, the evaluation of the participant's performance, including grades received, may be substituted for a formal, standardized educational assessment.

(2) When using historical information as an indicator of future success, changes in the participant's mental status, physical status, life circumstances, and motivation shall be given consideration.

93.5(5) *Assessment after FIP cancellation or limited benefit plan.* FIP participants who previously participated in either a basic or additional assessment and then were canceled from FIP or entered a limited benefit plan may be required to complete an assessment again when the PROMISE JOBS worker determines that updated information is needed for development or amendment of the FIA.

93.5(6) *Participants with FaDSS services only.* For participants with FaDSS services as the only activity in their FIA, the PROMISE JOBS worker shall use information provided by the FaDSS worker to help assess when a participant is ready to participate in other PROMISE JOBS activities. The PROMISE JOBS worker may require additional assessments to be completed if more information is needed to decide the type or level of the participant's involvement in other PROMISE JOBS activities.

93.5(7) *Documenting participation.* The participant shall provide documentation of participation in assessments as described at subrule 93.10(2). Persons who miss any portion of a scheduled assessment may be required to make up the missed portion, based on worker judgment and participant needs.

93.5(8) *Supportive payments allowed.* Except for assessment activities that occur on the same day as orientation, persons participating in assessment activities are eligible for payments for transportation and child care needed to allow the scheduled participation as described at rule 441—93.11(239B). When make-up sessions are required, the participant shall not receive an additional transportation payment, but necessary child care shall be paid.

93.5(9) *Failure to complete assessment.* Participants who do not complete assessments that are written into their FIA shall be considered to have chosen the limited benefit plan unless they have good cause. Procedures at 441—93.14(239B) shall apply.

441—93.6(239B) *Job readiness and job search activities.* Job readiness and job search activities include job club, job search, workplace essentials training, substance abuse treatment, mental health treatment, and other rehabilitation activities. The participant and the PROMISE JOBS worker shall incorporate into the FIA the job readiness and job search activities that are appropriate for the goals, work history, skill level, and life circumstances of the participant.

93.6(1) *Job club.* Job club prepares participants to search for work. Job club consists of training in job-seeking skills and structured job search.

a. Delivery of services. Job club is provided over a consecutive three-week period. Each week consists of 30 hours of structured activity.

(1) Generally, the first week of job club consists of job-seeking skills training and the next two weeks consist of structured group job search.

(2) Based on local office need and resources, the 30 hours of job-seeking skills training may be completed over the first two weeks when the hours not spent in job-seeking skills training are spent in structured job search. The total time spent in each of the two weeks must meet the 30-hour requirement. The third week of job club is 30 hours of structured group job search.

b. Job-seeking skills training. Job-seeking skills training may include but is not limited to:

- (1) Résumé development;
- (2) Writing application and follow-up letters;
- (3) Completing job applications and interest and skills assessments;
- (4) Job retention skills;
- (5) Motivational exercises;
- (6) Identifying and eliminating employment barriers;
- (7) Self-marketing;
- (8) Finding job leads;
- (9) Obtaining interviews;
- (10) Use of telephones for job seeking;
- (11) Interviewing skills; and
- (12) Financial education.

c. Structured job search. A written plan shall be developed with each participant using Form 470-4481, Job Search Plan Agreement, indicating the number of job search hours required depending on family circumstances and other component activities listed on the participant's FIA. Structured job search includes daily reporting to the job search site to access resources for job leads.

d. Attendance. Daily attendance is required during both the job-seeking skills training and structured job search. Participants who miss any portion of the job-seeking skills training or structured

job search may be required to either make up the missed portion of the sessions or to retake the entire week of training based on practical worker judgment and participant need.

(1) Participants who obtain employment are required to continue the job-seeking skills training unless the scheduled job club hours conflict with the scheduled hours of employment.

(2) Participants who obtain employment averaging 30 hours or more per week may discontinue the structured job search portion of job club.

(3) Participants who obtain employment averaging 20 hours per week or more but less than 30 hours per week may discontinue the structured job search portion of job club if part-time employment was the FIA goal or the scheduled job club hours conflict with the scheduled hours of employment. The participant may be required to participate in other FIA activities during the hours that do not conflict with work hours.

(4) Participants who obtain employment averaging less than 20 hours per week shall continue the structured job search portion of job club unless the scheduled job club hours conflict with the scheduled hours of employment. The participant may be required to participate in other FIA activities during the hours that do not conflict with work hours.

e. Supportive payments allowed. Child care and transportation payments shall be provided as described at rule 441—93.11(239B) when needed to participate in job club. The transportation payment shall be paid in full at the start of participation.

(1) Participants who must repeat the job-seeking skills training or structured job search because of absence due to reasons as described at rule 441—93.14(239B) shall receive an additional transportation payment as described at subrule 93.11(3) for each day that must be repeated and a child care payment for needed child care. This rule applies only when the participant will have transportation costs that exceed the participant's original payment because of repeating a portion of job club.

(2) Participants who must repeat job-seeking skills training or structured job search as a result of absences due to reasons other than those described at rule 441—93.14(239B) shall not receive an additional transportation payment.

f. Documenting job club participation. Participants shall provide documentation of job search activities as described at subrule 93.10(2).

g. Failure to participate in job club activities. Participants who without good cause do not appear for scheduled job club activities or who fail to complete or document and submit job search contacts according to their written plan shall be considered to have chosen the limited benefit plan. Procedures at 441—93.14(239B) shall apply.

93.6(2) Individual job search. Individual job search shall be available to all participants, particularly those who have recent ties with the workforce, have successfully removed or reduced barriers to work, or have completed job club or training and are now ready to work. If after three calendar months the participant still has not found employment, the worker shall review the participant's situation for possible barriers to employment or possible need for training to increase the participant's employability. Job search may continue if appropriate, but linking with other activities should be considered.

a. Job search plan. In consultation with the PROMISE JOBS worker, the participant shall design and provide a written plan of the individual job search activities on Form 470-4481, Job Search Plan Agreement. The plan shall:

(1) Contain a designated period for job search not to exceed five weeks ending on a Friday within the same calendar month and the specific methods for finding job openings.

(2) Specify the number of hours to be committed for each week of the designated period so as to provide the most effective use of transportation funds.

(3) Specify due dates for providing documentation of job search activities.

(4) Contain information as specific as possible about areas of employment interest, employers to be contacted, and other pertinent factors.

b. Supportive payments allowed. Child care and transportation payments shall be provided as described at rule 441—93.11(239B) when needed for participation in individual job search. The transportation payment shall be paid in full at the start of each designated period of the individual

job search. Transportation payments for any missed days of job search activity shall be subject to transportation overpayment policies as described at subrule 93.11(3).

c. Documenting job search participation. The participant shall document the actual hours spent on job contacts and other job search activities. Participant documentation shall be provided as described at subrule 93.10(2).

d. Failure to participate in individual job search. Participants who without good cause do not complete the steps of the written plan of the individual job search shall be considered to have chosen the limited benefit plan. Procedures at 441—93.14(239B) shall apply.

93.6(3) Unplanned job opportunity. PROMISE JOBS participants who have an unplanned opportunity to interview or apply for a job shall be encouraged to take advantage of the opportunity.

a. Supportive payments allowed. Child care and transportation payments needed to make an unplanned job contact shall be provided as described at rule 441—93.11(239B) when the following conditions are met:

- (1) The participant has a signed FIA,
- (2) The job contact is an in-person contact to complete an application or to attend an interview, and
- (3) The participant provides documentation as described in paragraph “b” of this subrule. Payment shall be issued after documentation is received.

b. Documenting participation. The participant shall provide documentation of the actual time spent making the specific job contact. Documentation shall be provided as described at subrule 93.10(2).

c. Limited benefit plan. A limited benefit plan does not apply when a participant fails to complete a job contact that is not part of a structured or individual job search plan.

93.6(4) Workplace essentials. The workplace essentials component consists of soft skills and life-skills training.

a. Delivery of services. Workplace essentials training is one 30-hour week in duration. Based on local office need and resources, the 30 hours may be completed over a two-week period. For the remainder of the 30 participation hours required in each week, participants must engage in other PROMISE JOBS activities.

b. Content. Workplace essentials training may include but is not limited to:

- (1) Identifying and setting goals.
- (2) Self-esteem building.
- (3) Emotional awareness.
- (4) Relationship management.
- (5) Conflict-resolution skills.
- (6) Problem-solving skills.
- (7) Decision-making skills.
- (8) Time-management skills.
- (9) Team-building skills.
- (10) Networking skills.
- (11) Listening skills.
- (12) Positive thinking.
- (13) Priority setting.
- (14) Appropriate workplace behaviors.
- (15) Cultural sensitivity.
- (16) Workplace expectations.
- (17) Stress management.

c. Supportive payments allowed. Child care and transportation payments shall be provided as described at rule 441—93.11(239B) when needed to participate in workplace essentials.

d. Documenting participation. The PROMISE JOBS worker shall verify and document each participant’s monthly hours of actual participation in workplace essentials. Participant documentation shall be provided as described at subrule 93.10(2).

e. Failure to participate in workplace essentials. Participants who without good cause do not complete workplace essentials as identified in their FIA shall be considered to have chosen the limited benefit plan. Procedures at 441—93.14(239B) shall apply.

93.6(5) Substance abuse treatment, mental health treatment, and other rehabilitative activities. Substance abuse or mental health treatment or other rehabilitative activities are available when needed for a participant to be successful in participating in other FIA activities.

a. Treatment determination. The need for treatment or rehabilitative activities must be determined by a qualified medical professional, substance abuse professional, or mental health professional. The qualified professional must document that treatment or rehabilitative activities are needed for the participant to obtain or retain employment.

b. Supportive payments allowed. Transportation and child care payments as described at rule 441—93.11(239B) are available for participating in substance abuse treatment, mental health treatment, or other rehabilitative activities when specified in the FIA.

c. Documenting participation. The service provider shall verify actual hours of participation in treatment. Documentation of participation shall be provided as described at subrule 93.10(2).

d. Failure to participate in treatment or other rehabilitative activities. Participants who without good cause do not participate in substance abuse treatment, mental health treatment, or other rehabilitative activities as specified in their FIA shall be considered to have chosen the limited benefit plan. Procedures at 441—93.14(239B) shall apply.

[ARC 1146C, IAB 10/30/13, effective 1/1/14]

441—93.7(239B) Work activities. Work activities include full-time employment, part-time employment, self-employment, on-the-job training, work experience placement, and unpaid community service. The participant and the PROMISE JOBS worker shall incorporate into the FIA employment activities that are appropriate for the work history, skill level, and life circumstances of the participant. If the FIA activity is so hazardous that safety glasses, hard hats, or other safety equipment is needed, participation shall not be arranged or approved unless these safety precautions are available.

93.7(1) Full-time or part-time employment. FIAs may include full-time employment or part-time employment. Employment that does not lead to economic self-sufficiency may be included in the FIA only if the employment situation leads to better employment opportunities through building work skills and work history. See subrule 93.7(2) for additional policies applicable to self-employment.

a. Full-time employment. The goal for all participants is to participate in full-time employment. “Full-time employment” is defined as being employed an average of 30 or more hours per week.

(1) Persons who have not achieved self-sufficiency through full-time employment before the end date of the FIA may have the FIA extended.

(2) Persons who choose not to enter into the renegotiation process to extend the FIA shall be considered to have chosen the limited benefit plan.

b. Part-time employment. Part-time employment is defined as being employed an average of less than 30 hours per week. An FIA that includes part-time employment shall also include participation in other PROMISE JOBS activities, including additional part-time employment, unless barriers to participation exist as defined in rule 441—93.14(239B) and subrule 93.4(5).

c. Supportive payments allowed. Transportation expenses are not paid through PROMISE JOBS but are covered by FIP earned income deductions. Child care payments shall be provided when needed as described at rule 441—93.11(239B).

d. Verification of employment hours. Participants must provide verification of employment hours as described at subrule 93.10(2).

e. Failure to provide verification. Failure to provide verification of work hours after receiving a written reminder will result in a limited benefit plan.

f. Failure to maintain employment. A participant who without good cause does not maintain employment as identified in the FIA shall be considered to have chosen the limited benefit plan. Procedures at 441—93.14(239B) shall apply.

93.7(2) Self-employment.

a. Calculation of hours. Hours of participation for persons who are self-employed shall be calculated using actual gross income less business expenses divided by the federal minimum wage. PROMISE JOBS shall use the same income as used for FIP eligibility and benefits.

(1) Participants with self-employment income that equates to 30 or more hours per week are considered to be working full-time.

(2) Participants with self-employment income that equates to less than 30 hours per week are considered to be working part-time.

b. Review of participation. The PROMISE JOBS worker shall review calculated hours:

(1) When income changes, or

(2) At least once every six months.

c. Progress toward self-sufficiency. At the participant's FIA review, the participant's progress is determined by noting incremental increases in income and calculated work hours. In order to maintain self-employment as the only FIA activity, participants must:

(1) Reach full-time employment as defined in subparagraph 93.7(2) "a"(1), or

(2) Show progress toward self-sufficiency.

d. Requiring other FIA activities. When a participant has been self-employed for more than 12 months and has not shown progress toward self-sufficiency, the FIA shall include the part-time self-employment in combination with participation in other PROMISE JOBS activities, unless barriers to participation exist as described in subrule 93.4(5).

(1) The other activities could include additional part-time employment.

(2) When the determination that a participant has not shown progress toward self-sufficiency is made after the initial FIA is developed, the FIA shall be renegotiated to include the other PROMISE JOBS activities. Participants who choose not to enter into the FIA renegotiation process shall enter into a limited benefit plan as described in 441—subrule 41.24(8).

e. Supportive payments allowed. Transportation expenses are not paid through PROMISE JOBS but are covered by FIP earned income deductions. Child care payments shall be provided when needed as described at subrule 93.11(2).

f. Documenting participation. Hours of participation in self-employment shall be calculated as specified in paragraph 93.7(2) "a" and documented in the case file. Participant documentation shall be provided as described at subrule 93.10(2).

g. Failure to maintain employment. Participants who without good cause do not maintain employment as identified in their FIA shall be considered to have chosen the limited benefit plan. Procedures at 441—93.14(239B) shall apply.

93.7(3) On-the-job training.

a. Definition. "On-the-job training" is defined as training in the public or private sector that:

(1) Is given to a paid employee while the employee is engaged in productive work, and

(2) Provides knowledge and skills essential to the full and adequate performance of the job.

b. Supportive payments. Transportation for on-the-job training is treated in the same manner as transportation for employment. Expenses are not paid through PROMISE JOBS but are covered by FIP earned income deductions. Child care payments shall be provided when needed as described at subrule 93.11(2).

c. Documenting participation. Documentation of participation shall be provided as described at subrule 93.10(2).

d. Failure to participate in on-the-job training. Participants who without good cause do not participate in on-the-job training as identified in their FIA shall be considered to have chosen the limited benefit plan. Procedures at 441—93.14(239B) shall apply.

93.7(4) Work experience program. Work experience sites shall provide participants with work experience and on-the-job training opportunities.

a. Sponsors. Employers who participate in the work experience program are referred to as sponsors. Work experience sponsors may be public sector, private sector, community-based, faith-based, or nonprofit employers.

(1) Participants may be placed at work sites with religious institutions only when the work performed is nonsectarian and not in support of sectarian activities.

(2) Participants may not be used to replace regular employees in the performance of nonsectarian work for the purpose of enabling regular employees to engage in sectarian activities.

(3) Each work experience program sponsor shall provide to the PROMISE JOBS service provider a copy of the sponsor's safety rules before participants are referred for work site placement.

b. Positions. To request a work experience placement, the sponsor shall complete Form 470-0809, Sponsor's Request for Work Experience (WEP) Participant, for each type of position the sponsor wishes to fill. The request shall include a complete job description that specifies all tasks to be performed by the participant. PROMISE JOBS has final authority to determine suitability of any work experience position offered by a sponsor. Work experience positions:

(1) Must contain the same job description and performance requirements that would exist if the sponsor were hiring an employee for the same position;

(2) Shall not be related to political, electoral, or partisan activities;

(3) Shall not be developed in response to or in any way be associated with the existence of a strike, lockout, or other bona fide labor dispute;

(4) Shall not violate any existing labor agreement between employees and employers;

(5) Shall comply with applicable state and federal health and safety standards;

(6) Shall not be used by sponsors to displace current employees or to infringe on the promotional opportunities of current employees;

(7) Shall not be used in place of hiring staff for established vacant positions; and

(8) Shall not result in placement of a participant in a position when any other person is on layoff from the same or an equivalent position in the same unit.

c. Participant selection. A participant's vocational skills and interests shall be matched as closely as possible with the job description and skills required by the sponsor.

(1) Participant responsibility. Participants shall interview for and accept positions offered by work experience sponsors. Participants shall present Form 470-0810, Referral for Work Experience (WEP) Placement, to the sponsor at the interview. The form shall be completed by the sponsor and returned to PROMISE JOBS.

(2) Sponsor responsibility. Although sponsors are expected to accept work experience referrals made by PROMISE JOBS, sponsors may refuse any referrals they deem inappropriate for the available position. Sponsors shall not discriminate against any program participant because of race, color, religion, sex, age, creed, physical or mental disability, political affiliation, or national origin. Sponsors who refuse a referral must notify PROMISE JOBS in writing of the reason for the refusal.

d. Hours of participation. When a participant is involved in work experience that is subject to the Fair Labor Standards Act (FLSA), the participant cannot be required to work more hours than the amount of the monthly FIP grant divided by federal or state minimum wage, whichever is higher. EXCEPTION: To determine the maximum hours that can be required of a single-parent family on FIP with a child under the age of six, add the value of the family's food assistance to the FIP grant amount before dividing by the minimum wage.

(1) A participant cannot be required to work more hours than those calculated under paragraph "d" of this subrule. Only hours up to or less than that calculation can be included in the participant's FIA.

(2) If two or more members of the same household participate in work experience, the total required hours of participation of the household cannot exceed the hours calculated according to paragraph "d" of this subrule.

(3) Each work experience assignment shall not exceed six months in duration.

e. Participant performance evaluations.

(1) Monthly evaluations. Sponsors shall complete a monthly evaluation of the participant's performance using Form 470-0805, Work Experience Participant Evaluation, and provide a copy to PROMISE JOBS and to the participant.

(2) Final evaluations. Sponsors shall complete Form 470-0805, Work Experience Participant Evaluation, at the time of termination for each work experience participant. When termination occurs

at the sponsor's request, the sponsor shall specify the reason for termination and identify those areas of unsatisfactory performance. For participants who leave to accept regular employment or reach their work experience placement time limit, the sponsor's evaluation shall indicate whether or not a positive job reference would be provided if the participant requested one.

f. Supportive payments for work experience placements.

(1) Child care and transportation. Participants assigned to work experience shall receive a child care payment, if required, and a transportation payment for each month or part thereof as described at subrules 93.11(2) and 93.11(3). The portion of the transportation payment for job-seeking activities shall be determined by including the day of the job search obligation in the normally scheduled days used in the formulas described at subrule 93.11(3).

(2) Required clothing and equipment. A participant may receive up to a limit of \$100 per work-site assignment for clothing or equipment if required by the work experience site and not covered by the sponsor.

(3) Workers' compensation. The department of human services shall provide workers' compensation coverage for all PROMISE JOBS work experience participants.

g. Documenting participation. Documentation of participation shall be provided as described at subrule 93.10(2).

h. Completion of work experience. Persons who complete a work experience assignment may move to another activity as provided under the FIA, be assigned to a different work site, or be reassigned to the same work site, whichever is appropriate under the FIA.

i. Failure to participate in work experience. A participant who without good cause does not participate in work experience as identified in the FIA shall be considered to have chosen the limited benefit plan. Procedures at rule 441—93.14(239B) shall apply.

93.7(5) Unpaid community service. Unpaid community service shall provide participants with opportunities to establish or reestablish contact with the workforce while providing services that are of direct benefit to the community.

a. Work sites. Unpaid community service work sites shall be public or private nonprofit organizations. The PROMISE JOBS provider agencies shall provide community service work sites a written explanation of the following placement criteria. The placement:

- (1) Shall comply with applicable state and federal health and safety standards;
- (2) Shall not be related to political, electoral or partisan activities;
- (3) Shall not be developed in response to or in any way associated with the existence of a strike, lockout, or other bona fide labor dispute;
- (4) Shall not violate any existing labor agreement between employees and employers;
- (5) Shall not be used to displace current employees or to infringe on their promotional opportunities;
- (6) Shall not be used in place of hiring staff for established vacant positions; and
- (7) Shall not result in placement of a participant in a position when any other person is on layoff from the same or an equivalent position in the same unit.

b. Locating the work site. The PROMISE JOBS provider agencies shall develop local listings of potential unpaid community service work sites. When a participant and the PROMISE JOBS worker agree that an unpaid community service placement is appropriate, the participant is responsible for locating and making arrangements with the work site. Formal interviews are not required to establish the relationship between the participant and the work site organization.

c. Length of assignment and weekly hours. The length of the work site assignment and the weekly hours of participation shall be determined through agreement among the work-site organization, the participant, and the PROMISE JOBS worker. When a participant is involved in community service that is subject to the Fair Labor Standards Act (FLSA), the participant cannot be required to work more hours than the amount of the participant's monthly FIP grant divided by federal or state minimum wage, whichever is higher. Only hours up to or less than the maximum calculated may be included in the participant's FIA. Exceptions are as follows:

(1) For a participant who is a single parent with a child under the age of six, the maximum hours that can be required are determined by adding the value of the participant's food assistance to the FIP grant amount before dividing by the minimum wage.

(2) Participants who are court-ordered to do community service shall work the number of hours required by the court.

e. Supportive payments. A child care payment and a transportation payment for each month of participation or part thereof shall be paid as described at rule 441—93.11(239B) if these services are required for participation.

f. Documenting participation. Documentation of participation shall be provided as described at subrule 93.10(2).

g. Failure to complete unpaid community service. Participants who without good cause do not participate in unpaid community service as specified in their FIA shall be considered to have chosen the limited benefit plan. Procedures at rule 441—93.14(239B) shall apply.

[ARC 1694C, IAB 10/29/14, effective 1/1/15]

441—93.8(239B) Education and training activities. Education refers to any academic or vocational course of study that enables a participant to complete high school, improves a participant's ability to read and speak English, or prepares a participant for a specific professional or vocational area of employment. Though employment leading to economic self-sufficiency is the eventual goal of all FIAs, it is recognized that education increases a person's chance of finding employment, particularly employment that leads to economic self-sufficiency. Any participant who requests participation in educational activities shall be evaluated to determine the likelihood of success. If the request is approved, a training plan shall be developed and included in the participant's FIA.

93.8(1) Participant requirements. The decision to include education in an FIA shall take into account the results of the educational evaluation pursuant to paragraph "b" of this subrule and the current educational level of the participant. Prior academic or vocational training is not, in itself, a reason for denial or approval of educational services. All family members who are approved for education shall be eligible for all program benefits, even when two or more family members are simultaneously participating and even if participation is at the same educational facility and in the same program. For education to be approved for inclusion in an FIA, the following requirements shall be met.

a. Vocational goal. For a participant enrolled in postsecondary education, the education must lead to a specific vocational goal. A degree in general studies or programs not leading to specific occupational outcomes cannot be included in a participant's FIA.

(1) Except as provided in subparagraph 93.8(1) "a"(2), a vocational goal must be in an occupational field for which available labor market information or emerging business trends in the participant's local area indicate employment potential. These trends or statistics must be provided by a legitimate source, such as but not limited to:

1. The department of workforce development,
2. Private employment agencies, or
3. Local employers providing jobs paying at least minimum wage for which the education is being requested.

(2) Information to support employment potential in the participant's local area is not required when:

1. The participant has a documented job offer in the field before entering the training; or
2. The participant is willing to relocate after training to an area where there is employment potential. Documentation for the new location shall meet the requirements in subparagraph 93.8(1) "a"(1).

(3) For participants attending high school or high school equivalency activities, adult basic education or English as a second language, the vocational goal is to improve employability by successfully completing the activity.

b. Evaluation. A participant under the age of 19 does not need to complete an educational evaluation in order to have high school completion included in the FIA. For every other training activity,

an educational evaluation shall be completed according to this paragraph before the activity is included as part of a participant's FIA.

(1) A participant who chooses to enter educational activities before obtaining approval is not eligible to receive supports as described in subrule 93.8(6), cannot use that activity to meet the FIA participation obligation, and shall be expected to participate in other FIA activities.

(2) A participant who is already involved in education at the time of FIP application or enters education before approval must meet the requirements in this rule before the educational activities can be included in the FIA. Once approved, the current educational activity may then be included in the participant's FIA, and the participant will be eligible to receive supports as described in subrule 93.8(6).

93.8(2) Provider requirements. Both public and private agencies may provide educational activities.

a. Type of provider. Education may be included in the FIA if obtained from a provider that is approved or registered with the state or is accredited by an appropriate accrediting agency. Training provided by a community action program, church, or other agency may be included in the FIA only if the PROMISE JOBS worker determines that:

(1) The training is adequate and leads to the completion of the participant's vocational goal; and

(2) The training provider possesses appropriate and up-to-date equipment; has qualified instructors, adequate facilities, a complete curriculum, acceptable grade point requirements, and a good job-placement history; and demonstrates expenses of training that are reasonable and comparable to the costs of similar programs.

b. Time and attendance. The participant's actual hours attending an educational activity must be verified pursuant to subrule 93.10(2). If the educational activity is structured in such a way that verification cannot be obtained or the educational provider is unwilling to provide time and attendance verification, the educational activity cannot be included in the participant's FIA.

93.8(3) Approvable activities. Training plans shall include only training activities that can be considered as meeting the FIA obligations for participation. The following activities may be included in a training plan:

a. Adult basic education.

b. Continuing education units when needed for the participant to be recertified or retrained to reenter a field in which the participant was previously trained or employed or to maintain certification needed to remain employed.

c. Correspondence courses when the courses are required but not offered by an educational facility attended by the participant.

d. English as a second language.

e. High school or high school equivalency completion. Any participant who does not have a high school diploma or high school equivalency diploma (HSED) shall be encouraged to obtain a diploma. A participant who is 18 years of age or older may be approved to return to regular high school only when the participant can graduate within one year of the normal graduation date. High school equivalency or high school courses and other types of vocational training may run concurrently.

f. On-line or distance learning. Distance learning includes training such as, but not limited to, that conducted over the Iowa communications network, on-line courses, or Web conferencing. The training:

(1) Must include interaction between the instructor and the student, such as required chats or message boards;

(2) Must include mechanisms for evaluation and measurement of student achievement; and

(3) Must be offered in Iowa unless the conditions in paragraph "g" of this subrule apply. An on-line training program shall be considered an out-of-state training program when any of the required training or testing occurs out-of-state.

g. Out-of-state training. Out-of-state training is approvable only when:

(1) Similar training is not available in Iowa,

(2) Relocation required to attend an in-state facility would be unnecessary if attending an out-of-state facility, or

(3) The only in-state facilities within commuting distance are private schools where tuition costs are higher than at an out-of-state facility within commuting distance.

h. Postsecondary education up to and including a baccalaureate degree program.

(1) A participant with no postsecondary education may be approved for training resulting in a certificate of program completion or an academic degree, such as an associate or baccalaureate degree. Participants who have not completed a high school education or received a high school equivalency diploma (HSED) may be required to do so before courses leading to an associate degree or higher are approved.

(2) A participant who has a baccalaureate degree or higher is considered employable. No further training shall be approved unless the participant's physical or mental status has changed to such an extent that the past education is no longer appropriate. The participant must provide supportive evidence from either a qualified medical or mental health professional or the state rehabilitation agency.

(3) A participant who has successfully completed a postsecondary educational program that provides less than a baccalaureate degree may be approved for further training if the participant meets one of the following criteria:

1. The previous training is in an occupation that is outdated.
 2. The previous training is in a field where current labor market information or emerging business trends show little or no employment opportunity.
 3. The training requested is a progression in a specific career that moves a participant from entry-level positions to higher levels of pay, skill, responsibility, or authority.
 4. The participant's background makes employment in the area in which the participant is trained impossible.
 5. Changes in the participant's physical or mental status make the past training no longer appropriate. The participant must provide supportive evidence from a qualified medical or mental health professional or the state rehabilitation agency.
- i.* Prerequisite courses required by the selected training program.
 - j.* Remedial coursework for one term when needed as determined by testing conducted by the training facility.
 - k.* Summer school.

93.8(4) *Nonapprovable activities.* Nonapprovable training activities shall not be included in the FIA. When an activity in which the participant is enrolled becomes nonapprovable, PROMISE JOBS shall cancel the current training plan and require the participant to renegotiate the FIA to include other activities. Form 470-0602, Notice of Decision: Services, shall be issued to inform the participant that the request for education is canceled. Nonapprovable activities include the following:

- a.* A course or training that the participant has previously completed.
- b.* Any course or training in a field in which the participant does not intend to seek employment after the training is completed. An exception may be made when the reason for not seeking employment is to receive further education when the education:
 - (1) Is a planned progression in a specific career path; and
 - (2) Will not lead to an advanced degree beyond a baccalaureate.
- c.* A training program that does not relate to the identified vocational goal.
- d.* Educational activities for which the participant has failed to earn the grades required for admission.
- e.* Education in a field in which the participant will not be able to be employed due to known criminal convictions or founded child or dependent adult abuse.
- f.* Out-of-state training except as allowed under paragraph 93.8(3) "g."
- g.* Training for jobs paying less than state minimum wage.
- h.* Training that will not be completed until after the participant leaves FIP. Training programs that exceed the known length of time during which the participant will remain eligible for FIP assistance shall be approved only if:
 - (1) The time remaining in the training is minimal and tuition has already been paid.
 - (2) There is a reasonable plan for how the program will be completed without the assistance and support from FIP or PROMISE JOBS. A reasonable plan may include, but not be limited to, school loans, grants, and scholarships.

93.8(5) *Training plan content.* Once a participant is approved for training, a training plan shall be developed and written into the participant's FIA. The training plan shall include:

a. Academic enrollment hours. Participants are encouraged to maintain as full an academic workload as is possible in order to complete their education in a timely manner. However, a person may choose to participate in education along with other activities such as employment, job-seeking skills, or other FIA activities.

b. Approved training plan activities.

c. The specific educational goal as defined in paragraph 93.8(1) "*a.*"

d. A date by which the participant expects to complete training. This end date depends on:

(1) Time frames specified for a program as established by the educational facility.

(2) Whether the participant is attending full-time or part-time.

(3) Problems or barriers to involvement as identified in subrule 93.4(5) or 93.14(1).

e. Testing schedule. Participants enrolled in ABE or ESL programs must be able to complete training in the time determined by the testing schedule unless the PROMISE JOBS worker and, if appropriate, the participant's academic advisor or instructor agree that additional time may be allowed. Under no circumstances, however, shall more than 6 additional months be allowed. Additional time shall not be allowed if, as a result, months required to complete training would exceed 24 months for ABE or 12 months for ESL.

93.8(6) *Supportive payments.* PROMISE JOBS may provide payment for certain expenses when needed to participate in approved education and training activities as described in this subrule and in subrule 93.11(4).

a. Eligibility.

(1) Eligibility for PROMISE JOBS supportive payments for education and training begins with the date when the participant begins training under an approved plan or is removed from a waiting list as described at paragraph 93.4(4) "*d.*" whichever is later.

(2) Participant eligibility for payment of transportation and child care payments begins as described in subparagraph 93.8(6) "*a*"(1) and shall be terminated when a training plan is canceled.

(3) Each participant in postsecondary vocational training is limited to 24 fiscal months of PROMISE JOBS payment of expenses needed for participation. The 24 fiscal months do not have to be consecutive. See paragraph "*b*" of this subrule for additional limits on child care expenses.

(4) When more than one facility offers a particular program, payment is limited to the amount required to attend the nearest educational facility except when attending a facility that is farther away will allow the family to reach self-sufficiency earlier.

b. Child care. Participants assigned to educational activities shall receive a child care payment, if required, for each month or part thereof as described at subrule 93.11(2). EXCEPTION: Each PROMISE JOBS participant is limited to 24 fiscal months of child care assistance.

(1) All child care assistance payments issued under the PROMISE JOBS program count toward this limit.

(2) All child care assistance payments issued for child care provided on or after March 1, 2009, count toward this limit, including payments issued while the person was not a PROMISE JOBS participant, pursuant to 441—subparagraph 170.2(2) "*b*"(1).

c. Transportation. Participants assigned to educational activities shall receive a transportation payment for each month or part thereof as described at subrule 93.11(3) unless transportation payments are available from another source.

(1) When a participant receives a transportation payment from another program which equals or exceeds that possible under PROMISE JOBS, transportation shall not be paid by PROMISE JOBS for any month covered by the other program.

(2) When the amount received from another program is less than that possible under PROMISE JOBS, a supplemental payment may be made as long as the combined payment does not exceed that normally paid by PROMISE JOBS.

(3) When a participant is enrolled in high school, a transportation payment shall not be allowed if transportation is available from another source, such as the school district. If child care needs or the needs

of the child or the participant make it impractical or inappropriate for the participant to use transportation provided by the school district, a transportation payment may be authorized.

d. Training expenses. Participants enrolled in high school or high school equivalency completion, ABE, ESL, or postsecondary vocational training may be eligible for payment of the following expenses of training when required for participation, subject to limits in subrule 93.11(4):

- (1) Enrollment fees,
- (2) School application fees,
- (3) Educational grant or scholarship application fees,
- (4) Licensing, certification and testing fees,
- (5) Travel costs required for certification or testing, and
- (6) Certain practicum expenses as described in subparagraph 93.11(4)“a”(3).

e. Direct education costs. Participants enrolled in high school or high school equivalency completion, ABE, ESL, or short-term training programs of 29 weeks or less may also be eligible for payment for direct education costs, including:

- (1) Tuition,
- (2) Books,
- (3) Fees including graduation,
- (4) Basic school supplies,
- (5) Specific supplies related to obtaining credit for a course and required of all students in a course, and
- (6) Required uniforms.

f. Supplies purchased with PROMISE JOBS funds. Participants who successfully complete their training plans may keep any books or supplies, including tools, which were purchased with PROMISE JOBS funds. Participants who leave their training program before completion and do not obtain training-related employment within 60 days of leaving training shall return all reusable supplies, including books and tools, but not clothing, purchased by PROMISE JOBS.

(1) The PROMISE JOBS worker is authorized to donate to nonprofit organizations any items determined to be unusable by the PROMISE JOBS program.

(2) When tools are not returned, the amount of the PROMISE JOBS payment shall be considered an overpayment unless the participant verifies theft of the tools through documentation of timely report to a law enforcement agency.

93.8(7) Documentation.

a. Plan. The following information shall be documented in the participant's file.

- (1) Evaluation results, pursuant to paragraph 93.8(1)“b.”
- (2) Current educational level.
- (3) Justification for approval of additional postsecondary education pursuant to subrule 93.5(3).
- (4) Academic probationary status pursuant to subrule 93.8(8).
- (5) Justification for denial of education. Form 470-0602, Notice of Decision: Services, shall be issued to the participant to deny the request for education.

b. Participation. A participant shall provide documentation of the actual hours of participation in education and homework and of grades and academic progress as described in subrule 93.10(2).

93.8(8) Academic probation. A participant may be placed on academic probation for at least one term, or a comparable time limit appropriate to the educational program, after which the participant shall be reevaluated for continued inclusion in education activities. This subrule does not apply to parents under the age of 18 who are attending high school completion programs.

a. Placing a participant on academic probation. The PROMISE JOBS worker may choose to place a participant on academic probation in the following circumstances:

(1) The educational evaluation completed according to paragraph 93.8(1)“b” identifies some factors with the participant's ability or past circumstances that could make successful completion of the training difficult but the participant's motivation is high and changes in the participant's life situation indicate a realistic probability of success.

(2) The participant was previously unable to maintain the cumulative grade point average required by a training facility in training comparable to that being requested.

(3) The participant enrolled but did not complete a previous education activity without good cause.

(4) At the end of a term, or of a comparable period applicable to the educational program, the participant is receiving less than a 2.0 grade point average or less than a higher average that is required by the specific training facility or curriculum.

b. Probation outcomes. The participant shall be removed from probation for satisfactory performance if, by the end of the established probationary period, the participant is receiving at least a 2.0 grade point average or a higher average as required by the specific training facility or curriculum.

(1) *Reevaluation.* If the participant is not receiving the required grade point by the end of the probationary period, the participant shall be reevaluated to determine continued eligibility for participation in education using the same type of information used to originally evaluate the likelihood of academic success as identified in paragraph 93.8(1) “b.” Documentation shall meet the requirements as stated in subrule 93.8(7).

(2) *Continued probation.* Probation may be continued when reevaluation indicates that education is appropriate. The PROMISE JOBS worker may also consider continued probation when:

1. Temporary barriers such as illness or family emergencies that interfered with successful participation have been resolved.

2. Long-term barriers to successful participation have been identified and accommodations developed and implemented.

3. The counselor or the lead instructor in the educational program verifies that there is an excellent likelihood the student will raise the grade point to the acceptable level in the next term or a comparable time limit appropriate to the educational program.

(3) *Cancellation of a training plan.* The participant’s current training plan shall be canceled if the participant has failed to maintain at least a 2.0 grade point average or a higher average required by the specific training facility or curriculum, and reevaluation indicates no mitigating circumstances as listed in subparagraph 93.8(8) “b”(2). When a training plan is canceled, the participant will be required to renegotiate the family investment agreement to include either a new, more appropriate training plan or other FIA activities. Form 470-0602, Notice of Decision: Services, shall be issued to the participant to inform the participant that the approval for education is canceled.

93.8(9) Limited benefit plan. Participants in education choose a limited benefit plan through the following actions.

a. Failure to participate. The participant fails to maintain education activities or follow training plan requirements as specified in the participant’s FIA, and the participant does not have good cause. Procedures at rule 441—93.14(239B) shall apply.

b. Misuse of payments. The participant misuses expense payments to the extent that the training plan is no longer achievable or knowingly provides receipts or any other written statements that have been altered, forged, or, in any way, are not authentic.

[ARC 1694C, IAB 10/29/14, effective 1/1/15]

441—93.9(239B) Other FIA activities.

93.9(1) Parenting skills training.

a. Parents aged 20 or older. For parents who are aged 20 or older when the FIA is signed, activities that strengthen the participant’s ability to be a better parent can be considered approvable training under PROMISE JOBS and may be included in the FIA as long as the participant is active in at least one other PROMISE JOBS component. Parents aged 20 or older who do not carry out the parenting skills training described in the FIA shall be considered to have chosen the limited benefit plan, unless family circumstances warrant renegotiation and amendment of the FIA.

b. Parents aged 19 or younger. Parents aged 19 or younger when the FIA is signed are required to include parenting skills training in the FIA, but may be excused from the requirement when documentation of satisfactory completion of parenting skills training is provided before the FIA is signed.

(1) Priority for orientation or assessment. In any month, PROMISE JOBS shall give priority for orientation or assessment services to parents who are already aged 19 in order to establish their responsibility for parenting classes before they are aged 20. This applies to those who are scheduled for orientation, to those who are still in assessment, and to those who have an FIA that must be renegotiated and amended.

(2) FIA requirement. The FIA shall be written or renegotiated and amended to include specific plans for parenting skills training and shall identify the training provider's name and beginning and ending dates of the training. The scheduled training may be in the future to accommodate availability of provider resources. However, it shall occur as soon as is compatible with the circumstances of the family, the other activities in the FIA, and the availability of provider resources, except as specified at paragraph 93.4(4) "d."

(3) Parents aged 19 or younger who are participating in a parenting skills training program at the time the FIA is signed shall be allowed to continue in that program, if they choose, as long as the provider is listed in paragraph 93.9(1) "c" or meets the requirements of paragraph 93.9(1) "c" and documentation of enrollment is provided. The time frames as described in paragraph 93.9(1) "d" shall be used to determine the remaining training time to be included in the FIA.

(4) Participation in other activities. Parents aged 19 or younger are not required to be participating in another PROMISE JOBS component to be eligible for parenting skills training. Other PROMISE JOBS components are included in the FIA according to policies at subrule 93.4(4).

c. Approved providers. The sources listed in this paragraph are approvable providers for parenting skills training.

(1) High school departments of family and consumer sciences that offer child development, family relationships, or parenting classes and alternative high school programs for pregnant and parenting teens. Services shall be limited to a minimum of one semester and a maximum of two semesters.

(2) Community colleges, other associate-degree institutions, and baccalaureate-degree institutions that offer child development, family relationships, or parenting classes. Services shall be limited to one semester or two quarters.

(3) Area education agencies; child abuse prevention programs; child and adult food program sponsors; child care resource and referral agencies; family resource centers; maternal and child health centers; family development and self-sufficiency program grantees and other family development providers; Head Start, Head Start parent and child centers, and Early Head Start programs; Iowa State University Extension services such as, but not limit to, the "Best Beginnings" program; private nonprofit social service agencies; and young parent support and information organizations. Services shall be limited to:

1. A minimum of 6 contact hours or six weeks, whichever comes first, and
 2. A maximum of 26 contact hours or six calendar months, whichever comes first.
- d. Other providers of parenting skills training are approvable as long as they:

(1) Have five of these six elements: child growth and development, child health and nutrition, child safety, positive discipline, relationships, and life skills.

(2) Offer training within the following time frames:

1. A minimum of 6 contact hours or six weeks, whichever comes first, and
2. A maximum of 26 contact hours or six calendar months, whichever comes first.

e. Supportive payments. For participants described in paragraphs 93.9(1) "a" and 93.9(1) "b," a child care payment and a transportation payment for each month of participation, or part thereof, as described at subrule 93.11(3), shall be paid if these services are not available from another entity and are required for participation.

(1) Other expenses. Payment for tuition, fees, or books and supplies shall be made only when parenting skills training is not available from a free source in the local area. PROMISE JOBS shall not pay for any expenses that are covered by student financial aid in postsecondary educational institutions as provided elsewhere in these rules.

(2) Continuation of payments. If the participant chooses to continue with the parenting skills training program beyond the designated period of participation described in paragraph 93.9(1) "c,"

PROMISE JOBS responsibility for payment of expense payments shall not extend beyond the designated period unless completion is delayed by acceptable instances for nonparticipation as stipulated at rule 441—93.14(239B) or barriers to participation at subrule 93.4(5).

f. Participation in parenting skills training. The planned duration of the parenting skills training shall be determined by agreement between the participant and the training provider within the limits described in paragraphs 93.9(1)“*c*” and 93.9(1)“*d*.”

(1) In consultation with the PROMISE JOBS worker, the participant and the provider shall design a written agreement and provide a copy to PROMISE JOBS. The agreement shall designate the period during which the mandatory parenting skills training requirement will be fulfilled. The period specified in the agreement or notice of decision shall be included in the FIA.

(2) Participants who fail to carry out this step in the FIA shall be considered to have chosen the limited benefit plan.

g. Failure to complete parenting skills training. Parents aged 19 or younger who do not include parenting skills training in the FIA or do not carry out the parenting skills training described in the FIA shall be considered to have chosen the limited benefit plan. Procedures at rule 441—93.14(239B) shall apply.

93.9(2) Family development. Family development services are support services for PROMISE JOBS families at risk of long-term dependency on public assistance. The services are designed to promote, empower, and nurture the family to self-sufficiency and healthy reintegration into the community.

a. PROMISE JOBS may arrange for family development services from entities that meet one of the following criteria wherever these are available. Family development services shall be:

(1) Provided by a family development specialist certified by the University of Iowa College of Social Work, National Resource Center on Family-Based Services; or

(2) Provided under a plan that has been approved by the family development and self-sufficiency (FaDSS) council of the department of human rights.

b. Inclusion of family development services by participants as a family investment agreement activity is voluntary except for unmarried parents aged 17 and younger who do not live with a parent or legal guardian as described at subparagraph 93.4(4)“*c*”(4).

93.9(3) Family planning counseling. Referral for family planning counseling is an optional service that shall be offered to each applicant or participant. It is not a component of PROMISE JOBS.

a. The department of human services worker or the PROMISE JOBS worker shall:

(1) Discuss orally and in writing the financial implications of newly born children on the participant’s family during PROMISE JOBS orientation or assessment, using a form approved by the department; and

(2) Review information about the basics of family planning; and

(3) Provide a listing of resources in the participant’s county of residence or the service delivery area.

b. The FIA shall record participant response to the option of referral for family planning counseling. It is not acceptable for the FIA to have family planning counseling as the only step of the FIA.

c. Supportive payments. No supportive payments are allowed for family planning counseling.

d. Participation. Limited benefit plan policies do not apply to participants who choose not to include family planning counseling in the FIA or who do not carry out the steps of family planning counseling.

[ARC 1146C, IAB 10/30/13, effective 1/1/14]

441—93.10(239B) Required documentation and verification.

93.10(1) Written notification to participants.

a. Notice of meetings, assignments, and issues. PROMISE JOBS shall notify participants in writing of all scheduled meetings, of FIA activity and work-site assignments, and of any participation issues as described at rule 441—93.13(239B). PROMISE JOBS shall also notify the participant in

writing when the participant is required to provide medical documentation, verification of hours of participation, employment verification, or any other verification.

(1) PROMISE JOBS shall allow a participant five working days from the date notice is mailed to appear for scheduled meetings unless the participant agrees to an appointment that is scheduled to take place in less than five working days.

(2) PROMISE JOBS shall allow a participant five working days from the date notice is mailed to appear for an FIA activity or work-site assignment or to provide medical documentation, employment verification, or any other verification, except as otherwise specified in 93.10(2).

(3) PROMISE JOBS shall allow additional time upon request from the participant when the participant is making every effort but is unable to fulfill requirements within the established time frame.

b. Notice of decision. PROMISE JOBS shall send written notice to each participant in accordance with 441—Chapter 7 when services are approved, rejected, renewed, changed, canceled, or terminated for failure to cooperate or participate. PROMISE JOBS services are approved when the participant is assigned to begin participation in an activity as written in the FIA.

93.10(2) Verification of participation and progress. Hours of participation and a participant's progress in FIA activities must be documented and verified. When the participant is responsible for providing the verification, PROMISE JOBS shall notify the participant in writing as required in subrule 93.10(1).

a. FIA activities directly monitored by PROMISE JOBS. When the FIA activities are provided or directly monitored by PROMISE JOBS staff, such as job club or workplace essentials, the staff will document the participant's hours of attendance and progress in the case file.

b. FIA activities not directly monitored by PROMISE JOBS. When FIA activities are provided by a service provider other than PROMISE JOBS, the provider shall verify the participant's hours of attendance with Form 470-2617, PROMISE JOBS Time and Attendance Report, unless another method is required by this rule.

(1) The provider is expected to specify the participant's hours of attendance and to sign and date the Time and Attendance Report.

(2) The participant is responsible for providing the signed and dated form to PROMISE JOBS within ten calendar days following the end of each month, unless the provider provides the form to PROMISE JOBS within this time frame.

(3) EXCEPTION: If the participant is under age 20 and in high school or high school equivalency classes, the participant may verify the hours by completing and submitting the PROMISE JOBS Time and Attendance Report monthly. The training provider does not need to sign the form.

c. Documentation of job search. The participant shall complete and provide documentation of any job search activities that cannot be verified by the PROMISE JOBS worker. The participant shall provide Form 470-3099, Job Search Record, within ten calendar days following the end of each month during which the participant has made a job search. The PROMISE JOBS worker shall consider the Job Search Record complete if the form includes:

(1) Sufficient information to identify the employer that was contacted or the activity that was completed,

(2) The date that the contact was made or the date the activity was completed,

(3) The amount of time spent, and

(4) The participant's signature.

d. Employment verification. Participants shall verify actual hours of employment at the time that employment begins, upon FIP approval if employed at the time of application, when changes in hours occur, and no less than once every six months thereafter. Participants may use employer statements or copies of pay stubs, Employer Statement of Earnings Form 470-2844, or may sign Form 470-0429, Consent to Obtain and Release Information, so that the employer may provide information directly to the PROMISE JOBS worker. Participants shall provide verification of actual hours of employment within five working days of the written request from PROMISE JOBS.

e. Documentation of self-employment. At the time of the participant's FIA review, a self-employed participant shall provide documentation of actual hours worked and gross income and business expenses

from the last 30 days. Data from more than 30 days may be requested if the last month is not indicative of normal business. The participant shall provide documentation within five working days of the written request from PROMISE JOBS.

f. Distance learning. When a participant is involved in a distance-learning program, PROMISE JOBS will accept the documentation issued by the distance-learning institution verifying that the student participated in the sessions.

(1) Documentation may include the attendance records or log-in and log-out records available on line or in an electronic format. Documentation may also be obtained through an agreement with a support agency that monitors the student's actual participation.

(2) The participant is responsible for providing the documentation within ten calendar days following the end of each month unless the institution provides the documentation to PROMISE JOBS within this time frame.

g. Failure to provide required documentation or verification. Participants who fail to provide documentation or verification as described in this subrule after written notification from PROMISE JOBS as described in subrule 93.10(1) shall be considered to have chosen the limited benefit plan. Procedures at rule 441—93.14(239B) shall apply.

93.10(3) Verification of problems or barriers. Participants may be required to provide written verification or supporting documentation of reported problems or barriers to participation, such as but not limited to lack of transportation, family emergency, or existence of a mental or physical disability or limitation or substance abuse.

a. Medical documentation. A participant shall secure and provide written documentation signed by a qualified medical or mental health professional to verify a claimed illness or disability within five working days of a written request by PROMISE JOBS. This time limit may be extended due to individual circumstances, such as the need to obtain an updated evaluation. Acceptable verification includes Form 470-0447, Report on Incapacity, or other statement signed by a qualified medical or mental health professional to verify the existence of an illness, disability, or limitation.

b. Other documentation. A participant shall secure and provide written documentation to verify a claimed problem or barrier to participation within five working days of a written request by PROMISE JOBS. Acceptable documentation may include a signed statement from a third party with knowledge of the problem or barrier.

c. Failure to verify problem or barrier or to provide medical documentation. Failure to provide verification of a problem or barrier or to provide medical documentation as described at subrule 93.10(3) does not directly result in the imposition of a limited benefit plan. Examples of actions that do not directly result in a limited benefit plan include, but are not limited to, failure to provide Form 470-0447, Report on Incapacity, or other statement from a medical or mental health professional to verify the existence of an illness or disability, or a statement from a third party with knowledge about the problem or barrier.

(1) Participants who claim an inability to participate on a full-time basis due to a claimed problem or barrier and who fail to provide verification or medical documentation upon written request may be required to renegotiate the FIA to include full-time participation in FIA activities. Failure to renegotiate the FIA may result in a limited benefit plan.

(2) Participants who claim a problem or barrier caused their failure to participate for the full number of hours identified in their FIA and who fail to provide verification of the problem or barrier or medical documentation upon written request may not be excused for the failure to participate. If the failure is not excused, the failure will result in imposition of a limited benefit plan if the failure meets the criteria described at subrule 93.13(2).

[ARC 1146C, IAB 10/30/13, effective 1/1/14; ARC 1694C, IAB 10/29/14, effective 1/1/15]

441—93.11(239B) Supportive payments. In order to facilitate successful participation, PROMISE JOBS may provide payment for the expenses listed in this rule. Participants shall submit Form 470-0510, Estimate of Cost, to initiate payments or change the amount of payment for expenses other than child care.

93.11(1) *Eligibility.* Participants are eligible for supportive payments needed for participation in activities in their FIA, subject to the limits in this chapter.

a. Applicants in a limited benefit plan who must complete significant contact with or action in regard to PROMISE JOBS for FIP eligibility to be considered, as described at 441—paragraphs 41.24(8) “*a*” and “*d*,” are eligible for expense payments for the 20 hours of activity. However, PROMISE JOBS services and supportive payments are only available when it appears the applicant will otherwise be eligible for FIP.

b. Applicants who have received 60 months of FIP are eligible for PROMISE JOBS services and payments under the circumstances described at 441—subrule 41.30(3).

93.11(2) *Child care.* Payments for child care shall be issued through the child care assistance program as described at 441—Chapter 170.

a. Payment shall be provided for child care if:

- (1) Care is needed for participation in any PROMISE JOBS activity other than orientation,
- (2) Payment is not specifically prohibited elsewhere in these rules, and
- (3) Payment is not available from another source.

b. Payment shall be issued to the child care provider after the service has been received, as described in 441—subrule 170.4(7).

93.11(3) *Transportation.* Participants may receive a transportation payment for each day that transportation is needed for participation in a PROMISE JOBS activity. Transportation payments shall be determined according to the circumstances of each participant. If necessary, payments shall cover transportation for the participant and child from the participant’s home to the child care provider and to the PROMISE JOBS site or activity.

a. Exclusions.

(1) A transportation payment is not available for orientation or for assessment activities that occur on the same day as orientation.

(2) A transportation payment is not available for employment. Participants who are employed shall be entitled to the work expense deduction described at 441—paragraph 41.27(2) “*a*” to cover transportation costs associated with employment.

b. Rate of payment. Payments shall not exceed the rate that the provider would charge a private individual.

(1) Public transportation. For those who use public transportation, the payment shall be based on the normally scheduled days of participation in the PROMISE JOBS activity for the period covered by the payment, using the rate schedules of the local transit authority to the greatest advantage, including use of weekly and monthly passes or other rate reduction opportunities.

(2) Private transportation. For participants who use a privately owned motor vehicle or who hire private transportation, the transportation payment shall be based on a formula which uses the normally scheduled days of participation in the PROMISE JOBS activity for the period covered by the payment multiplied by the participant’s anticipated daily round-trip miles and then multiplied by the mileage rate of 30 cents per mile.

c. Special transportation needs. Participants who require, due to a mental or physical disability, a mode of transportation other than a vehicle they operate themselves shall be eligible for payment of a supplemental transportation payment when documented actual transportation costs are greater than transportation payments provided under these rules and transportation is not available from another source.

(1) Medical evidence. To be eligible for a supplemental payment, the participant must provide medical evidence of the need for an alternate mode of transportation due to disability or incapacity. EXCEPTION: A finding of eligibility for social security benefits or supplemental security income benefits based on disability or blindness is acceptable proof of disability. The evidence must be from a qualified medical or mental health professional or the state rehabilitation agency. The evidence may be submitted either by letter from the qualified medical or mental health professional or on Form 470-0447, Report on Incapacity.

(2) Resources for examination. When an examination is required and other resources are not available to meet the expense of the examination, the PROMISE JOBS worker shall authorize the examination and submit a claim for payment on Form 470-0502, Authorization for Examination and Claim for Payment.

(3) Payment rates. Actual costs of transportation by a public or private agency shall be allowed. Costs of transportation provided by private automobile shall be allowed as described in subparagraph 93.11(3)“b”(2).

d. Issuance of payments. The transportation payment shall be issued before the first scheduled day of participation in an activity. For participants in the same activity for more than one month, transportation payments shall be issued before the first day of the month of scheduled participation except as described below.

(1) Transportation payments for assessment shall be issued in advance in weekly increments, with payments for the second or third week of assessment being issued as soon as it is determined that the participant will be required to participate in the second or third week of assessment.

(2) Payments for the third and subsequent months of an ongoing activity shall not be authorized before receipt of time and attendance verification, as described at subrule 93.10(2), for the month before the issuance month. EXAMPLE: A transportation payment for June, normally issued after May 15 to be available to the participant by June 1, will not be authorized until time and attendance verification for the month of April has been received in the PROMISE JOBS office.

(3) The amounts of payments for the third and subsequent months of an ongoing activity shall be adjusted by subtracting from normally scheduled days any number of days which represents a difference between the number of scheduled days of activity in the month before the issuance month and the number of actual days attended in that month. EXAMPLE: A transportation payment is issued in May based on 16 scheduled days of participation for June. The participant attends only 14 days of the activity. When preparing to issue the August transportation allowance, the worker subtracts two days from the normally scheduled August activities to calculate the payment. If ten days of participation are scheduled, the transportation payment issued in July for August is calculated using eight days.

(4) Because adjustment for actual attendance is not possible in the last two months of an ongoing activity, transportation payments for the last two months of an ongoing activity shall be subject to transportation overpayment provisions of paragraph 93.11(3)“e.”

EXCEPTION: A transportation overpayment does not occur for any month in which the participant leaves the PROMISE JOBS activity in order to enter employment.

e. Transportation overpayment. Payment for transportation shall be considered an overpayment subject to recovery in accordance with rule 441—93.12(239B) in the following instances:

(1) When the participant attends none of the scheduled days of participation in a PROMISE JOBS activity, the entire transportation payment shall be considered an overpayment. Recovery of the overpayment shall be initiated when it becomes clear that subsequent participation in the activity is not possible for reasons such as, but not limited to, family investment program ineligibility, establishment of a limited benefit plan, or exemption from PROMISE JOBS participation requirements.

(2) When the participant fails to attend 75 percent of the normally scheduled days of participation in either of the last two months of an ongoing PROMISE JOBS activity or in any transportation payment period of an activity which has not been used for payment adjustment as described at paragraph 93.11(3)“d,” an overpayment is considered to have occurred. The amount to recover shall be the difference between the amount for the actual number of days attended and the amount for 75 percent of normally scheduled days.

93.11(4) Training and education expenses. Participants shall use PROMISE JOBS payments that they receive to pay authorized expenses.

a. Classroom training. PROMISE JOBS payments for classroom training are limited as follows:

(1) Tuition payments for high school or high school equivalency completion, ABE, ESL, or short-term training programs of 29 weeks or less shall not exceed the rate charged by the Iowa community college located nearest the participant’s residence which offers a course or program comparable to the one in which the participant plans to enroll. If an Iowa community college does not

offer a comparable program, the maximum tuition rate payment shall not exceed the Iowa resident rate charged by the out-of-state area school located nearest the participant's residence.

(2) A standard payment for basic school supplies of \$10 per term or actual cost, whichever is higher, shall be allowed for those participants who request it. A claim for actual costs higher than \$10 must be verified by receipts.

(3) A per diem payment of \$10 for living costs during a practicum shall be allowed when the practicum is required by the curriculum of the training facility, would require a round-trip commuting time of three hours or more per day, and is not available closer to the participant's home. If practicum earnings or other assistance is available to meet practicum living costs, no payment shall be made.

(4) Payments may be authorized to meet the costs of travel required for certification and testing, not to exceed the transportation payment as described at subrule 93.11(3) and the current state employee reimbursement rate for meals and lodging.

(5) Funds may not be used to purchase supplies to enable a participant to begin a private business.

(6) No payment shall be made for jewelry, pictures, rental of graduation gowns, elective courses that require expenditures for field trips or special equipment, such as photography or art supplies, or other items that are not required to complete training for a vocational goal.

b. Retroactive payments. Retroactive payments for transportation and allowable direct education costs shall be allowed only under the following conditions:

(1) If plan approval or removal from a waiting list occurs after the start of the term due to administrative delay or worker delay, payments shall be approved retroactive to the start of the term for which the plan is approved or removal from the waiting list is authorized. If the participant has already paid costs with private resources, the participant shall be reimbursed.

(2) If plan approval is delayed due to the fault of the participant, payment eligibility shall begin with the first day of the month during which the plan is approved or the month in which the participant is removed from a waiting list as described at paragraph 93.4(4) "d," whichever is later. In this instance, there shall be no reimbursement for costs already paid by the participant.

c. Receipts. Participants shall furnish receipts for expenditures that they pay, except for transportation payments. Failure to provide receipts will preclude additional payments. Receipts may be requested for payments paid directly to the training provider if the PROMISE JOBS worker determines it is appropriate.

d. Payments directly to facility. PROMISE JOBS is authorized to provide payment for expenses allowable under these rules to the training facility for the educational expenses of tuition and fees and books and supplies which are provided by the facility and billed to the PROMISE JOBS participant. Payment may also be made to the participant in those situations where payment to the participant is determined to be appropriate by the PROMISE JOBS worker.

93.11(5) Other expenses.

a. Birth certificates. PROMISE JOBS funds shall be used to pay costs of obtaining a birth certificate when the birth certificate is needed in order for the participant to complete the workforce development registration process described in subrule 93.3(6).

b. Required clothing and equipment. A participant may receive up to a limit of \$100 per work-site assignment for clothing or equipment if required by the work experience site and not covered by the sponsor.

c. Workers' compensation. The department of human services shall provide workers' compensation coverage for all PROMISE JOBS work experience participants.

d. Workforce Investment Act. PROMISE JOBS funds may also be used to pay expenses for PROMISE JOBS participants enrolled in federal Workforce Investment Act (WIA) funded services or activities when those expenses are allowable under these rules.

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441—93.12(239B) Recovery of PROMISE JOBS expense payments. When an applicant, a participant, or a provider receives an expense payment for transportation or other supportive expenses

that is greater than allowed under these rules or receives a duplicate payment of an expense payment, an overpayment is considered to have occurred and recovery is required. There are two categories of PROMISE JOBS expense payments subject to recovery: (1) transportation, and (2) other supportive expense payments.

93.12(1) The PROMISE JOBS worker shall notify the department of inspections and appeals (DIA) to record the overpayment in the overpayment recovery system. The outstanding balance of any overpayments that occurred before July 1, 1990, shall be treated in the same manner.

93.12(2) The department of inspections and appeals shall notify the participant or the provider when it is determined that an overpayment exists, as described at 441—subrule 7.5(6).

a. Notification shall include the amount, date, and reason for the overpayment. Upon the participant's request, the local office shall provide additional information regarding the computation of the overpayment.

b. The participant may appeal the computation of the overpayment and any action to recover the overpayment through benefit reduction in accordance with 441—subrule 7.5(6). If a participant or provider files an appeal request, the PROMISE JOBS unit shall notify the DIA within three working days of receipt of the appeal request.

93.12(3) A PROMISE JOBS overpayment shall be recovered through repayment in part or in full. Repayments received by the PROMISE JOBS unit shall be transmitted to the Department of Human Services, Cashier's Office, Room 14, 1305 E. Walnut Street, Des Moines, Iowa 50319-0144.

a. Overpayments of PROMISE JOBS child care issued for any month before July 1999 shall be subject to recovery rules of the PROMISE JOBS program.

b. Overpayments of child care assistance issued for July 1999, and any month thereafter, are subject to recovery rules of the child care assistance program set forth in rule 441—170.9(234).

93.12(4) When a participant or a provider offers repayment in part or in full before the end of the 30-day appeal period, the PROMISE JOBS unit or the department of human services' local office shall accept the payment. If a subsequent appeal request is received, the PROMISE JOBS unit shall notify the DIA and shall not accept any further payments on the claim. The amount of the voluntary payment shall not be returned to the participant or provider unless the final decision on the appeal directs the department to do so.

93.12(5) When a participant or a provider has been referred to the DIA to initiate recovery, the DIA shall use the same methods of recovery as are used for the FIP program, described at DIA administrative rules 481—71.1(10A) to 71.9(10A), except that the FIP grant shall not be reduced to effect recovery without the participant's written permission.

a. When the participant requests grant reduction on Form 470-0495, Repayment Contract, the grant will be reduced for repayment as described in 441—subrule 46.25(3), paragraphs “a,” “b,” and “c.”

b. The DIA is authorized to take any reasonable action to effect recovery of provider overpayments such as, but not limited to, informal agreements, civil action, or criminal prosecution. However, the DIA shall not take any collection action on a provider overpayment that would jeopardize the participant's continued participation in the PROMISE JOBS program.

441—93.13(239B) Resolution of participation issues. PROMISE JOBS participants who do not carry out the responsibilities of the FIA shall be considered to have chosen the limited benefit plan, as described at 441—subrule 41.24(8). The participation issues listed in this rule are those that are important for effective functioning in the workplace or training facility and for the completion of the FIA.

93.13(1) Notification of participation issue. When participants appear to be choosing a limited benefit plan by not carrying out the FIA responsibilities, the PROMISE JOBS worker shall send one written reminder or letter as specified in subrule 93.10(1). The reminder or letter shall:

- a.* Clearly identify the participation issue and the specific action needed to resolve it,
- b.* Clarify expectations,
- c.* Attempt to identify barriers to participation that should be addressed in the FIA,
- d.* Explain the consequences of the limited benefit plan, and

e. Offer supervisory intervention.

93.13(2) Participation issues. Actions that may cause participants to be considered as having chosen the limited benefit plan when the participant does not have a problem or barrier to participation as defined at paragraph 93.4(5) “a” or rule 441—93.14(239B) are:

a. Tardiness. Participants who are more than 15 minutes late to a scheduled FIA activity for a third time within three months of the first tardiness, after receiving one written reminder at the time the second tardiness occurred.

b. Failure to attend scheduled activities. Participants who do not, for a second time after receiving one written reminder at the first occurrence, appear for scheduled appointments, participate in assessment activities, including taking required vocational or aptitude tests, complete or provide required forms other than those described at subrule 93.10(3) or are absent from activities designated in the FIA.

c. Absence from work experience. Participants who do not, for a second time after receiving one written reminder at the first occurrence, notify work experience sponsors or the PROMISE JOBS worker of an absence within one hour of the time at which they are due to appear.

d. Disruptive behavior. Participants who exhibit disruptive behavior for a second time after receiving one written reminder at the first occurrence. “Disruptive behavior” means the participant hinders the performance of other participants or staff, refuses to follow instructions, uses abusive language, or is under the influence of alcohol or drugs.

e. Unsatisfactory performance or participation. Participants whose performance or participation in an FIA activity continues to be unsatisfactory after PROMISE JOBS sends one letter as described in subrule 93.13(1).

f. Physical threats. Participants who make physical threats to other participants or staff and do not demonstrate that the participant is not at fault by providing written documentation from a doctor, licensed psychologist, probation officer, or law enforcement official after PROMISE JOBS sends one letter as described in subrule 93.13(1).

(1) “Physical threat” means having a dangerous weapon in one’s possession and either threatening with or using the weapon or committing assault.

(2) The documentation must verify that the act was caused by either a temporary problem or a serious problem or barrier that needs to be included in the FIA. The documentation must also provide reasonable assurance that the threatening behavior will not occur again.

g. Accepting work experience assignments. Participants who do not accept work experience assignments when the work experience is part of the FIA and do not demonstrate a problem or barrier that caused the failure after PROMISE JOBS sends one letter.

h. Work experience interviews. Participants who do not appear for work experience interviews for a second time after receiving a written reminder at the first occurrence.

i. Employment and other work activity issues. Participants who do not follow up on job referrals, who refuse offers of employment or other work activity, who reduce hours of employment or other work activity, who terminate employment or other work activity, or who are discharged from employment or other work activity due to misconduct.

(1) For the purposes of these rules, “misconduct” means a deliberate act or omission by the employed participant that constitutes a material breach of the duties and obligations arising out of the employee’s contract of employment. To be considered misconduct, the employee’s conduct must demonstrate deliberate violation or disregard of standards of behavior that the employer has the right to expect of employees. Mere inefficiency, unsatisfactory conduct, failure to perform well due to inability or incapacity, ordinary negligence in isolated instances, or good-faith errors in judgment or discretion shall not be deemed misconduct for the purpose of these rules.

(2) At the time of the occurrence, PROMISE JOBS shall send a letter to the participant regarding the misconduct. The letter shall give the participant an opportunity to resolve the issue by accepting a previously refused employment offer if available, returning to previously terminated employment if available, obtaining comparable employment, or demonstrating a problem or barrier that caused the failure.

j. Failure to secure child care. Participants who do not secure adequate child care when registered or licensed facilities are available after PROMISE JOBS sends one written reminder and when PROMISE JOBS has provided the participant with resources for locating adequate child care.

k. Inappropriate use of funds. Participants for whom child care, transportation, or educational services become unavailable as a result of failure to use PROMISE JOBS funds or child care assistance funds to pay the provider or failure to provide required receipts and who do not demonstrate a problem or barrier that caused the failure after PROMISE JOBS sends one letter.

l. Failure to follow training plan. Education participants who do not follow the requirements of a training plan in the FIA as described at rule 441—93.8(239B).

m. Failure to renegotiate the FIA. When a participant fails to respond to the PROMISE JOBS worker's request to renegotiate the FIA because the participant has not attained self-sufficiency by the date established in the FIA, a limited benefit plan shall be imposed regardless of whether the request to renegotiate is made before or after expiration of the FIA.

93.13(3) Choosing a limited benefit plan.

a. Before determining that a participant has chosen the limited benefit plan due to a potential participation issue, the PROMISE JOBS worker shall make every effort to negotiate a solution. Local PROMISE JOBS management has the option to involve an impartial third party to assist in a resolution process. Arrangements shall be indicated in the local services plan of the local service delivery region. As part of the resolution process, the PROMISE JOBS worker shall determine:

(1) Whether the participant has a problem that provides good cause for the participation issue, as described in rule 441—93.14(239B). If so, the participant shall be encouraged to take actions to fulfill the FIA.

(2) Whether participant circumstances indicate that a barrier to participation exists, as described in subrule 93.4(5). If so, the FIA shall be negotiated to address the barrier.

b. The participant may be considered to have chosen the limited benefit plan when all of the following occur:

(1) The participant is notified of a participation issue as described in subrule 93.13(1);
(2) The participant does not resolve the participation issue;
(3) The participant does not present acceptable evidence of a problem providing good cause for the issue as described in rule 441—93.14(239B); and

(4) The participant does not present acceptable evidence of a barrier to participation as described in subrule 93.4(5) or fails to renegotiate the FIA to address the identified barrier.

c. If the resolution process does not lead to fulfillment of the FIA, the case shall be referred for review by the administering or contracted service provider agency.

(1) The procedure may include review by state-level staff of the administering or contracted agency or by a regional PROMISE JOBS manager, a PROMISE JOBS supervisor, an income maintenance supervisor, or a combination of any of the above. Approval of any review procedure at less than the state level shall occur only after the service delivery region demonstrates satisfactory performance of the resolution process.

(2) The department of human services retains control and oversees review procedures even when another agency is contracted with to provide PROMISE JOBS services.

d. If the above steps do not lead to fulfillment of the FIA, the FIP participant is considered to have chosen the limited benefit plan and the notice of decision shall be initiated. The notice of decision shall inform the participant of:

(1) The action needed to reconsider the limited benefit plan as described at 441—subparagraph 41.24(8)“d”(1).

(2) Appeal rights under the limited benefit plan are described at rule 441—93.15(239B).

[ARC 1146C, IAB 10/30/13, effective 1/1/14; ARC 1208C, IAB 12/11/13, effective 2/1/14]

441—93.14(239B) Problems that may provide good cause for participation issues.

93.14(1) Problems leading to less than full participation. Problems affecting participation shall be considered to be of a temporary or incidental nature when the participation can easily be resumed. The

following problems may provide good cause for participation of less than the full number of hours identified in the FIA. PROMISE JOBS may require the participant to provide verification of the problem or barrier as described at subrule 93.10(3):

- a. Illness of the participant. When a participant is ill more than three consecutive days or if illness is habitual, the PROMISE JOBS worker may require medical documentation of the illness.
- b. Illness of family member. When a participant is required in the home due to illness of another family member, the PROMISE JOBS worker may require medical documentation.
- c. Family emergency, using reasonable standards of an employer.
- d. Bad weather, using reasonable standards of an employer.
- e. Absence or tardiness due to participant's or spouse's job interview. When possible, the participant shall provide notice of the interview at least 24 hours in advance including the name and address of the employer conducting the interview. When 24-hour notice is not possible, notice must be given as soon as possible and before the interview.
- f. Leave due to the birth of a child. When a child is born after referral, necessary absence shall be determined in accordance with the Family Leave Act of 1993.
- g. Court appearance.
- h. Attendance at school functions of the participant's children or children in the participant's household.
- i. Attendance at required meetings with the department of human services or PROMISE JOBS.
- j. Absence due to up to ten holidays per year.

(1) The participant must normally have been scheduled to work, or participate in an unpaid work activity on the given day and the work site or facility is closed due to a holiday, or open but the participant is allowed to take the participant's normally scheduled hours off on a different day.

(2) The holidays included are New Year's Day, Martin Luther King Day, President's Day, Memorial Day, Fourth of July, Labor Day, Veterans Day, Thanksgiving, the day after Thanksgiving, and Christmas.

93.14(2) *Problems leading to refusing or quitting a job or limiting or reducing hours.* The following problems may provide good cause for participation issues of refusing or quitting a job or limiting or reducing hours. PROMISE JOBS may require the participant to provide verification of the problem or barrier as described at subrule 93.10(3):

- a. Required travel time from home to the job or available work experience or unpaid community service site exceeds one hour each way. This includes additional travel time necessary to take a child to a child care provider.
- b. Except as described in 441—subrule 41.25(5), work offered is at a site subject to a strike or lockout, unless the strike has been enjoined under Section 208 of the Labor-Management Relations Act (29 U.S.C. 78A, commonly known as the Taft-Hartley Act), or unless an injunction has been issued under Section 10 of the Railway Labor Act (45 U.S.C. 160).
- c. The work site violates applicable state or federal health and safety standards or workers' compensation insurance is not provided.
- d. The job is contrary to the participant's religious or ethical beliefs.
- e. The participant is required to join, resign from or refrain from joining a legitimate labor organization.
- f. Work requirements are beyond the mental or physical capabilities as documented by medical evidence or other reliable sources.
- g. Discrimination by an employer based on age, race, sex, color, disability, religion, national origin or political beliefs.
- h. Work demands or conditions render continued employment unreasonable, such as working without being paid on schedule.
- i. Circumstances beyond the control of the participant, such as interruption of regular mail delivery or other disruptions of services.
- j. Employment change or termination is part of the FIA.
- k. Job does not pay at least the minimum amount customary for the same work in the community.

l. The participant terminates employment in order to take a better-paying job, even though hours of the new job may be less than those in the previous job.

m. The employment would result in the family of the participant experiencing a net loss of cash income. Net loss of cash income results if the family's gross income less necessary work-related expenses is less than the cash assistance the person was receiving at the time the offer of employment is made. Gross income includes, but is not limited to, earnings, unearned income, and cash assistance. Gross income does not include food stamp benefits and in-kind income.

n. The employment changes substantially from the terms of hire, such as a change in work hours or work shift or a decrease in pay rate.

93.14(3) *Other problems.* The PROMISE JOBS worker may identify circumstances that could negatively impact the participant's achievement of self-sufficiency that are not described in subrule 93.14(1) or 93.14(2). When this occurs, the case shall be referred to the administrator of the division of financial, health and work supports for a determination as to whether the problems are acceptable reasons for:

a. Not participating,

b. Refusing or quitting a job, or

c. Discharge from employment due to misconduct as described at paragraph 93.13(2) "i."

[ARC 1146C, IAB 10/30/13, effective 1/1/14]

441—93.15(239B) Right of appeal. In accordance with 441—Chapter 7, each applicant or participant is entitled to appeal and to be granted a hearing over disputes regarding: (1) services being received; (2) services which have been requested and denied, reduced, canceled, or inadequately provided; and (3) acts of discrimination on the basis of race, sex, national origin, religion, age or handicapping condition.

93.15(1) *Informal resolution process.* When there is a disagreement between the participant and the immediate PROMISE JOBS worker regarding the participant's FIA or participation in PROMISE JOBS components, the participant may request an interview with the supervisor and a decision on the dispute. The supervisor shall schedule a face-to-face interview with the participant within 7 days and issue a decision in writing within 14 days of the participant's request.

93.15(2) *Appeal on the content of the family investment agreement.* A participant shall have the right to appeal the content of the FIA when the informal resolution process described at subrule 93.15(1) does not resolve a disagreement between the participant and the PROMISE JOBS worker.

93.15(3) *Appeal of an alleged violation of PROMISE JOBS program policy.* Participants shall have the right to file a written appeal concerning any alleged violation of a PROMISE JOBS program policy that is imposed as a condition of participation. The responsible agency shall provide the participant with written documentation that specifies the participation requirement in dispute.

93.15(4) *Appeal rights under the limited benefit plan.* A participant has the right to appeal the establishment of the limited benefit plan only once, at the time the department issues the timely and adequate notice that establishes the limited benefit plan. However, when the reason for the appeal is based on incorrect grant computation, an error in determining the eligible group, or another worker error, a hearing shall be granted when the appeal otherwise meets the criteria for hearing.

93.15(5) *Request for a hearing on work conditions or availability of workers' compensation coverage.* A participant who is enrolled in the PROMISE JOBS program may request a hearing if dissatisfied with working conditions, the availability of workers' compensation coverage or the wage rate used in determining hours of work experience program participation.

a. When any involved party is dissatisfied with the department's final decision, the dissatisfied party shall be informed of the right to appeal the issue to the Secretary of Labor, Office of Administrative Law Judges, U.S. Department of Labor, Vanguard Building, Room 600, 111 20th Street N.W., Washington, DC 20036, within 20 days of receipt of the decision. The department may assist with the appeal upon request.

b. For the purposes of this rule, the department's final decision shall be considered received the second day after the date that the written decision was mailed, unless the intended recipient can

demonstrate that it was not received on the second day after the mailing date. When the second day falls on a Sunday or legal holiday, the time shall be extended to the next mail delivery day.

c. The option to appeal to the Secretary of Labor does not preclude an individual from exercising any right to judicial review provided in Iowa Code chapter 17A or as described in 441—Chapter 7.

441—93.16(239B) Resolution of a limited benefit plan.

93.16(1) *Resolution process for a first limited benefit plan.* For participants who choose a first limited benefit plan, the notice of decision shall inform the participant of the action needed to reconsider the limited benefit plan as described at 441—subparagraph 41.24(8) “d”(1).

a. The notice of decision establishing a first limited benefit plan shall inform the FIP participant that the participant may reconsider at any time from the date timely and adequate notice is issued establishing the limited benefit plan. The notice of decision shall inform the participant that the participant shall contact the department or appropriate PROMISE JOBS office to reconsider the limited benefit plan.

b. When the participant contacts either the income maintenance worker or the PROMISE JOBS office, the participant shall be scheduled to begin or resume development of the FIA as described elsewhere in these rules.

c. When the FIA is signed, the PROMISE JOBS worker shall notify the department and the limited benefit plan shall be terminated. FIP benefits shall be effective as described at 441—subparagraph 41.24(8) “d”(1).

93.16(2) *Resolution process for a subsequent limited benefit plan.* The notice of decision establishing a subsequent limited benefit plan shall inform the FIP participant of the six-month ineligibility period and that the participant may reconsider at any time following the six-month ineligibility period. To reconsider, the participant must complete significant contact with or action in regard to the PROMISE JOBS program as described at 441—subparagraph 41.24(8) “d”(3).

a. When the six-month ineligibility period ends and the participant contacts either the income maintenance worker or the PROMISE JOBS office, the participant shall be scheduled to sign a new or updated FIA and to begin significant action as described at 441—subparagraph 41.24(8) “d”(3).

b. When the FIA is signed and the participant has satisfactorily completed the significant action, the PROMISE JOBS worker shall notify the department and the limited benefit plan shall be terminated. FIP benefits shall be effective as described at 441—subparagraph 41.24(8) “d”(3).

441—93.17(239B) Worker displacement grievance procedure. The PROMISE JOBS program shall provide a grievance procedure to address and resolve public complaints regarding the displacement of regular workers with program participants in a work experience placement.

93.17(1) The procedure shall provide that:

a. Complaints must be filed in writing and received by the PROMISE JOBS service provider within one year of the alleged violation.

b. A representative of the PROMISE JOBS service provider must schedule a face-to-face interview with the complainant within 7 days of the date the complaint is filed, to provide the opportunity for informal resolution of the complaint.

c. Written notice of the location, date and time of the face-to-face interview must be provided.

d. An opportunity must be provided to present evidence at the face-to-face interview.

e. The representative of the PROMISE JOBS service provider shall issue a decision in writing within 14 days of the date a complaint is filed.

f. A written explanation must be provided to all involved parties of the right to file a written appeal, according to 441—Chapter 7, if the opportunity for informal resolution is declined, if a party receives an adverse decision from the PROMISE JOBS service provider, or if there is no decision within the 14-day period.

(1) To be considered, an appeal must be filed with the department within 10 days of the mailing date of the adverse decision or within 24 days of the date a complaint is filed

(2) An appeal hearing will not be granted until informal resolution procedures have been exhausted, unless a decision has not been issued within 24 days of the complaint filing date.

93.17(2) The department shall issue a final decision within 90 days of the date the complaint was filed with the PROMISE JOBS service provider.

93.17(3) Any dissatisfied party shall be informed of the right to appeal the decision of the department to the Secretary of Labor, Office of Administrative Law Judges, U.S. Department of Labor, Vanguard Building, Room 600, 111 20th Street N.W., Washington, DC 20036, within 20 days of the receipt of the department's final decision.

a. For the purposes of this rule, the department's final decision shall be considered received the second day after the date that the written decision was mailed, unless the intended recipient can demonstrate that it was not received on the second day after the mailing date. When the second day falls on a Sunday or legal holiday, the time shall be extended to the next mail delivery date.

b. The option to appeal to the Secretary of Labor does not preclude an individual from exercising any right to judicial review as provided in Iowa Code chapter 17A or as described in 441—Chapter 7.

93.17(4) Upon notice of a complaint or grievance, the PROMISE JOBS office must provide the complaining party with a copy of the grievance procedures, notification of the right to file a formal complaint and instruction on how to file a complaint.

93.17(5) Upon filing a complaint, and at each stage thereafter, each complainant must be notified in writing of the next step in the complaint procedure.

93.17(6) The identity of any person who has furnished information relating to, or assisting in, an investigation of a possible violation must be kept confidential to the extent possible, consistent with due process and a fair determination of the issues.

93.17(7) All employers who participate in the PROMISE JOBS program shall provide assurances that all regular employees are aware of this grievance procedure.

These rules are intended to implement Iowa Code section 239B.17 to 239B.22.

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CHAPTER 110
CHILD DEVELOPMENT HOMES

[Prior to 7/1/83, Social Services[770] Ch 110]

[Prior to 2/11/87, Human Services[498]]

PREAMBLE

This chapter establishes registration procedures for child development homes. Included are application and renewal procedures, standards for providers, and procedures for compliance checks and complaint investigation.

441—110.1(237A) Definitions.

“Adult” means a person aged 18 or older.

“Assistant” means a responsible person aged 14 or older. The assistant may never be left alone with children. Ultimate responsibility for supervision is with the child care provider.

“Child” means either of the following:

1. A person 12 years of age or younger.
2. A person 13 years of age or older but younger than 19 years of age who has a developmental disability, as defined under the federal Developmental Disabilities Assistance and Bill of Rights Act of 2000, Public Law No. 106-402, codified in 42 U.S.C. 15002(8).

“Child care” means the care, supervision, or guidance of a child by a person other than the child’s parent, guardian, or custodian for periods of less than 24 hours per day per child on a regular basis. Child care shall not mean special activity programs that meet on a regular basis such as music or dance classes, organized athletics or sports programs, scouting programs, or hobby or craft classes or clubs.

“Child care facility” or *“facility”* means a child care center, a preschool, or a registered child development home.

“Child care home” means a person or program providing child care to five or fewer children at any one time that is not registered to provide child care under this chapter, as authorized under Iowa Code section 237A.3.

“Child development home” means a person or program registered under this chapter that may provide child care to six or more children at any one time.

“Department” means the department of human services.

“Involvement with child care” means licensed or registered as a child care facility, employed in a child care facility, residing in a child care facility, receiving public funding for providing child care, providing child care as a child care home provider, or residing in a child care home.

“Parent” means parent or legal guardian.

“Part-time hours” means the hours that child development homes in categories B and C are allowed to exceed their maximum preschool or school-age capacity. A provider may use a total of up to 180 hours per month as part-time hours. No more than two children using part-time hours may be in the child development home at any one time.

“Person subject to an evaluation” means a person who has committed a transgression and who is described by any of the following:

1. The person is being considered for registration or is registered.
2. The person is being considered by a child care facility for employment involving direct responsibility for a child or with access to a child when the child is alone, or the person is employed with such responsibilities.
3. The person will reside or resides in a child care facility.
4. The person has applied for or receives public funding for providing child care.
5. The person will reside or resides in a child care home that is not registered but that receives public funding for providing child care.

“Provider” means the person or program that applies for registration to provide child care and is approved as a child development home.

“*Registration*” means the process by which child care providers certify that they comply with rules adopted by the department.

“*Registration certificate*” means the written document issued by the department to publicly state that the provider has certified in writing compliance with the minimum requirements for registration of a child development home.

“*School*” means kindergarten or a higher grade level.

“*Transgression*” means the existence of any of the following in a person’s record:

1. Conviction of a crime.
2. A record of having committed founded child or dependent adult abuse.
3. Listing in the sex offender registry established under Iowa Code chapter 692A.
4. A record of having committed a public or civil offense.
5. Department revocation or denial of a child care facility registration or license due to the person’s continued or repeated failure to operate the child care facility in compliance with licensing and registration laws and rules.

441—110.2(237A) Application for registration. A provider shall apply for registration on Form 470-3384, Application for Child Development Home Registration, provided by the department’s local office or, if available, on the department’s Web site. The provider shall also use Form 470-3384 to inform the department of any changes in circumstances that would affect the registration.

441—110.3(237A) Renewal. Renewal of registration shall be completed every 24 months. To request renewal, a provider shall submit Form 470-3384, Application for Child Development Home Registration, and copies of certificates of training, to be retained in the registration file. The renewal process shall include completion of child abuse, sex offender, and criminal record checks.

441—110.4(237A) Number of children. The number of children shall conform to the following standards:

110.4(1) Limit. Except as provided in subrule 110.4(3), no greater number of children shall be received for care at any one time than the number authorized on the registration certificate.

110.4(2) Children counted. In determining the number of children cared for at any one time in a child development home, each child present in the child development home shall be considered to be receiving care unless the child is described by one of the following exceptions:

a. The child’s parent, guardian, or custodian established or operates the child development home and either the child is attending school or the child receives child care full-time on a regular basis from another person.

b. The child has been present in the child development home for more than 72 consecutive hours and meets the requirements of the exception in paragraph “*a*” as though the person who established or operates the child development home is the child’s parent, guardian, or custodian.

110.4(3) Exception for emergency school closing. On days when schools are closed due to emergencies such as inclement weather or physical plant failure, a child development home may have additional children present in accordance with the authorization for the registration category of the home and subject to all of the following conditions:

a. The child development home has prior written approval from the parent or guardian of each child present in the home concerning the presence of additional children in the home.

b. The child development home has a department-approved assistant, aged 14 or older, on duty to assist the care provider, as required for the registration category of the home.

c. One or more of the following conditions are applicable to each of the additional children present in the child development home:

- (1) The home provides care to the child on a regular basis for periods of less than two hours.
- (2) If the child were not present in the child development home, the child would be unattended.
- (3) The home regularly provides care to a sibling of the child.

d. The provider shall maintain a written record including the date of the emergency school closing, the reason for the closing, and the number of children in care on that date.

441—110.5(237A) Standards. The provider shall certify that the child development home meets the following standards and also the standards in either rule 441—110.8(237A), 441—110.9(237A), or 441—110.10(237A), specific to the category of home for which the provider requests registration.

110.5(1) Health and safety. Conditions in the home shall be safe, sanitary, and free of hazards.

a. The home shall have a non-pay, working telephone with emergency numbers posted for police, fire, ambulance, and the poison information center. The number for each child's parent, for a responsible person who can be reached when the parent cannot, and for the child's physician shall be written on paper and readily accessible by the telephone. The home must prominently display all emergency information, and a paper copy of emergency parent contact information must be kept in all travel vehicles. If the working telephone is a mobile telephone, all emergency numbers must also be programmed and saved into the telephone.

b. All medicines and poisonous, toxic, or otherwise unsafe materials shall be secured from access by a child.

c. A first-aid kit shall be available and easily accessible whenever children are in the child development home, in the outdoor play area, in vehicles used to transport children, and on field trips. The kit shall be sufficient to address first aid related to minor injury or trauma and shall be stored in an area inaccessible to children.

d. Medications shall be given only with the parent's or doctor's written authorization. Each prescribed medication shall be accompanied by a physician's or pharmacist's direction. Both nonprescription and prescription medications shall be in the original container with directions intact and labeled with the child's name. All medications shall be stored properly and, when refrigeration is required, shall be stored in a separate, covered container so as to prevent contamination of food or other medications. All medications shall be stored so they are inaccessible to children.

e. Electrical wiring shall be maintained with all accessible electrical outlets safely capped and electrical cords properly used. Improper use includes running cords under rugs, over hooks, through door openings, or other use that has been known to be hazardous.

f. Combustible materials shall be kept away from furnaces, stoves, water heaters, and gas dryers.

g. Approved safety gates at stairways and doors shall be provided and used as needed.

h. A safe outdoor play area shall be maintained in good condition throughout the year. The play area shall be fenced off when located on a busy thoroughfare or near a hazard which may be injurious to a child, and shall have both sunshine and shade areas. The play area shall be kept free from litter, rubbish, and flammable materials and shall be free from contamination by drainage or ponding of sewage, household waste, or storm water.

i. Annual laboratory analysis of a private water supply shall be conducted to show satisfactory bacteriological quality. When children under the age of two are to be cared for, the analysis shall include a nitrate analysis. When private water supplies are determined unsuitable for drinking, commercially bottled water or water treated through a process approved by the health department or designee shall be provided.

j. Emergency plans in case of man-made or natural disaster shall be written and posted by the primary and secondary exits. The plans shall clearly map building evacuation routes and tornado and flood shelter areas.

k. Fire and tornado drills shall be practiced monthly and the provider shall keep documentation evidencing compliance with monthly practice on file.

l. A safety barrier shall surround any heating stove or heating element, in order to prevent burns.

m. The home shall have at least one 2A 10BC rated fire extinguisher located in a visible and readily accessible place on each child-occupied floor.

n. The home shall have at least one single-station, battery-operated, UL-approved smoke detector in each child-occupied room and at the top of every stairway. Each smoke detector shall be installed

according to manufacturer's recommendations. The provider shall test each smoke detector monthly and keep a record of testing for inspection purposes.

o. Smoking and the use of tobacco products shall be prohibited at all times in the home and in every vehicle in which children receiving care in the home are transported. Smoking and the use of tobacco products shall be prohibited in the outdoor play area during the home's hours of operation. Nonsmoking signs shall be posted at every entrance of the child care home and in every vehicle used to transport children. All signs shall include:

- (1) The telephone number for reporting complaints, and
- (2) The Internet address of the department of public health (www.iowasmokefreeair.gov).

p. Children under the age of one year shall be placed on their backs when sleeping unless otherwise authorized in writing by a physician.

q. Providers shall inform parents of the presence of any pet in the home.

(1) Each dog or cat in the household shall undergo an annual health examination by a licensed veterinarian. Acceptable veterinary examinations shall be documented on Form 470-5153, Veterinary Health Certificate. This examination shall verify that the animal's routine immunizations, particularly rabies, are current and that the animal shows no evidence of endoparasites (roundworms, hookworms, whipworms) and ectoparasites (fleas, mites, ticks, lice).

(2) Each pet bird in the household shall be purchased from a dealer licensed by the Iowa department of agriculture and land stewardship and shall be examined by a veterinarian to verify that it is free of infectious diseases. Acceptable veterinary examinations shall be documented on Form 470-5153, Veterinary Health Certificate. Children shall not handle pet birds.

(3) Aquariums shall be well maintained and installed in a manner that prevents children from accessing the water or pulling over a tank.

(4) All animal waste shall be immediately removed from the children's areas and properly disposed of. Children shall not perform any feeding or care of pets or cleanup of pet waste.

(5) No animals shall be allowed in the food preparation, food storage, or serving areas during food preparation and serving times.

r. When there is a swimming or wading pool on the premises:

(1) A wading pool shall be drained daily and shall be inaccessible to children when it is not in use.

(2) An aboveground or in-ground swimming pool that is not fenced shall be covered whenever the pool is not in use. The cover shall meet or exceed the standards of the American Society for Testing and Materials.

(3) An uncovered aboveground swimming pool shall be enclosed with an approved fence that is four feet above the side walls.

(4) An uncovered in-ground swimming pool shall be enclosed with a fence that is at least four feet high and flush with the ground.

s. If children are allowed to use an aboveground or in-ground swimming pool:

(1) Written permission from parents shall be available for review.

(2) Equipment needed to rescue a child or adult shall be readily accessible.

(3) The child care provider shall accompany the children and provide constant supervision while the children use the pool.

(4) The child care provider shall complete training in cardiopulmonary resuscitation for infants, toddlers, and children, according to the criteria of the American Red Cross or the American Heart Association.

t. Homes served by private sewer systems shall be compliant with environmental protection commission rules on wastewater treatment and disposal systems at 567—Chapter 69. Compliance shall be verified by the local board of health within 12 months of renewal or new registration.

u. The provider shall have written policies regarding the care of mildly ill children and exclusion of children due to illness and shall inform parents of these policies.

v. The provider shall have written policy and procedures for responding to health-related emergencies.

w. The provider shall document all injuries that require first aid or medical care using an injury report form. The form shall be completed on the date of occurrence, shared with the parent, and maintained in the child's file.

x. A provider operating in a facility built before 1960 shall assess and control lead hazards before being issued an initial child development home registration or a renewal of the registration. To comply with this requirement, the provider shall:

(1) Conduct a visual assessment of the facility for lead hazards that exist in the form of peeling or chipping paint;

(2) Apply interim controls on any chipping or peeling paint found, using lead-safe work methods in accordance with and as defined by department of public health rules at 641—Chapters 69 and 70, unless a certified inspector as defined in 641—Chapter 70 determines that the paint is not lead-based paint; and

(3) Submit Form 470-4755, Lead Assessment and Control, as verification of the visual assessment and completion of interim controls, if necessary.

EXCEPTION: Providers that have a valid registration on November 1, 2009, shall assess and control lead hazards by June 30, 2010.

110.5(2) Provider files. A provider file shall be maintained and shall contain the following:

a. A physical examination report. Providers and all members of a provider's household shall have good health as evidenced by a preregistration physical examination. Acceptable physical examinations shall be documented on Form 470-5152, Child Care Provider Physical Examination Report. The examination shall include any necessary testing for communicable diseases; shall include a discussion regarding current Advisory Committee on Immunization Practices (ACIP)-recommended vaccinations; shall be performed within six months prior to registration by a licensed medical doctor, doctor of osteopathy, physician assistant or advanced registered nurse practitioner; and shall be repeated at least every three years.

b. Certificates or other documentation from the department verifying the following:

(1) Required training as set forth in subrule 110.5(11).

(2) Completion of all record checks as required in subrule 110.7(3), at initial application, at each application for change and at each application for renewal.

c. An individual file for each staff assistant that contains:

(1) Documentation from the department confirming the record checks required under subrule 110.7(3) have been completed and authorizing or conditionally limiting the person's involvement with child care.

(2) A completed Form 470-5152, Child Care Provider Physical Examination Report, that meets the requirements of paragraph 110.5(2) "a."

(3) Certification of a minimum of two hours of approved training relating to the identification and reporting of child abuse, completed within six months of employment and every five years thereafter, as required by Iowa Code section 232.69.

d. An individual file for each substitute that contains:

(1) Documentation from the department confirming the record checks required under subrule 110.7(3) have been completed and authorizing or conditionally limiting the person's involvement with child care.

(2) A completed Form 470-5152, Child Care Provider Physical Examination Report, that meets the requirements of paragraph 110.5(2) "a."

(3) Certification of a minimum of two hours of approved training relating to the identification and reporting of child abuse, completed within six months of employment and every five years thereafter, as required by Iowa Code section 232.69.

(4) Certification in first aid that meets the requirements of paragraph 110.5(11) "b."

110.5(3) Activity program. There shall be an activity program which promotes self-esteem and exploration and includes:

a. Active play.

b. Quiet play.

c. Activities for large muscle development.

- d.* Activities for small muscle development.
- e.* Play equipment and materials in a safe condition, for both indoor and outdoor activities which are developmentally appropriate for the ages and number of children present.

110.5(4) The certificate of registration shall be displayed in a conspicuous place.

110.5(5) Parental access. Parents shall be afforded unlimited access to their children and to the people caring for their children during the normal hours of operation or whenever their children are in the care of the child development home, unless parental contact is prohibited by court order.

110.5(6) Discipline. Discipline shall conform to the following standards:

- a.* Corporal punishment including spanking, shaking and slapping shall not be used.
- b.* Punishment which is humiliating or frightening or which causes pain or discomfort to the child shall not be used.
- c.* Punishment shall not be administered because of a child's illness, or progress or lack of progress in toilet training, nor shall punishment or threat of punishment be associated with food or rest.
- d.* No child shall be subjected to verbal abuse, threats, or derogatory remarks about the child or the child's family.
- e.* Discipline shall be designed to help the child develop self-control, self-esteem, and respect for the rights of others.

110.5(7) Meals. Regular meals and midmorning and midafternoon snacks shall be provided which are well-balanced, nourishing, and in appropriate amounts as defined by the USDA Child and Adult Care Food Program. Children may bring food to the child development home for their own consumption, but shall not be required to provide their own food.

110.5(8) Children's files. An individual file shall be maintained for each child and updated annually or when the provider becomes aware of changes. The file shall contain:

- a.* Identifying information including, at a minimum, the child's name, birth date, parent's name, address, telephone number, special needs of the child, and the parent's work address and telephone number.
- b.* Emergency information including, at a minimum, where the parent can be reached, the name, street address, city and telephone number of the child's regular source of health care, and the name, telephone number, and relationship to the child of another adult available in case of emergency.
- c.* A signed medical consent from the parent authorizing emergency treatment.
- d.* An admission physical examination report signed by a licensed physician or designee in a clinic supervised by a licensed physician.
 - (1) The date of the physical examination shall not be more than 12 months before the child's first day of attendance at the child development home.
 - (2) The written report shall include past health history, status of present health, allergies and restrictive conditions, and recommendations for continued care when necessary.
 - (3) For a child who is five years of age or older and enrolled in school, a statement of health status signed by the parent or legal guardian may be substituted for the physical examination report.
 - (4) The examination report or statement of health status shall be on file before the child's first day of care.
- e.* A statement of health condition signed by a physician or designee submitted annually from the date of the admission physical. For a child who is five years of age or older and enrolled in school, a statement of health status signed by the parent or legal guardian may be substituted for the physician statement.
- f.* A list signed by the parent which names persons authorized to pick up the child. The authorization shall include the name, telephone number, and relationship of the authorized person to the child.
- g.* A signed and dated immunization certificate provided by the state department of public health. For the school-age child, a copy of the most recent immunization record shall be acceptable.
- h.* For each school-age child, on the first day of attendance, documentation of a physical examination that was completed at the time of school enrollment or since.

i. Written permission from the parent for the child to attend activities away from the child development home. The permission shall include:

- (1) Times of departure and arrival.
- (2) Destination.
- (3) Persons who will be responsible for the child.

j. Injury report forms documenting injuries requiring first aid or medical care.

110.5(9) Provider. The provider shall meet the following requirements:

- a.* Give careful supervision at all times.
- b.* Exchange information with the parent of each child frequently to enhance the quality of care.
- c.* Give consistent, dependable care and be capable of handling emergencies.
- d.* Be present at all times except when emergencies occur or an absence is planned, at which time care shall be provided by a department-approved substitute. When an absence is planned, the provider shall give parents at least 24 hours' prior notice.

110.5(10) Substitutes. The provider shall assume responsibility for providing adequate and appropriate supervision at all times when children are in attendance. Any designated substitute shall have the same responsibility for providing adequate and appropriate supervision. Ultimate responsibility for supervision shall be with the provider.

- a.* All standards in this chapter regarding supervision and care of children shall apply to substitutes.
- b.* Except in emergency situations, the provider shall inform parents in advance of the planned use of a substitute.

c. The substitute must be 18 years of age or older.

d. Use of a substitute shall be limited to:

- (1) No more than 25 hours per month.
- (2) An additional period of up to two weeks in a 12-month period.

e. The provider shall maintain a written record of the number of hours substitute care is provided, including the date and the name of the substitute.

110.5(11) Professional development.

a. The provider shall receive two hours of Iowa's training for mandatory reporting of child abuse:

- (1) During the first three months of registration as a child development home; and
- (2) Every five years thereafter.

b. The provider shall obtain first-aid training within the first three months of registration as a child development home.

(1) First-aid training shall be provided by a nationally recognized training organization, such as the American Red Cross, the American Heart Association, the National Safety Council, or Emergency Medical Planning (Medic First Aid) or by an equivalent trainer using curriculum approved by the department.

(2) First-aid training shall include certification in infant and child first aid that includes management of a blocked airway and mouth-to-mouth resuscitation.

(3) The provider shall maintain a valid certificate indicating the date of first-aid training and the expiration date.

c. During the first year of registration, the provider shall receive a minimum of 12 hours of training from one or more of the following content areas. The provider shall receive at least 6 of these hours in a group setting as defined in subrule 110.5(12), and 2 of the hours must be from the content area in subparagraph 110.5(11)"c"(1). A provider shall not use a specific training or class to meet minimum continuing education requirements more than one time every five years.

(1) Planning a safe, healthy learning environment (includes nutrition).

(2) Steps to advance children's physical and intellectual development.

(3) Positive ways to support children's social and emotional development (includes guidance and discipline).

(4) Strategies to establish productive relationships with families (includes communication skills and cross-cultural competence).

(5) Strategies to manage an effective program operation (includes business practices).

- (6) Maintaining a commitment to professionalism.
- (7) Observing and recording children's behavior.
- (8) Principles of child growth and development.

d. During the second year of registration and each succeeding year, the provider shall receive a minimum of 12 hours of training from one or more of the content areas as defined in paragraph "c." The provider shall receive at least 6 of these hours in a group setting as defined in subrule 110.5(12). The provider may receive the remaining hours in self-study as defined in subrule 110.5(13). A provider shall not use a specific training or class to meet minimum continuing education requirements more than one time every five years.

e. A provider who submits documentation from a child care resource and referral agency that the provider has completed the Iowa Program for Infant/Toddler Care (IA PITC), ChildNet, or Beyond Business Basics training series may use those hours to fulfill a maximum of two years' training requirements, not including first-aid and mandatory reporter training.

110.5(12) Group training. Training received in a group setting is not self-study, but is training received with other adults.

a. The training must be conducted by a trainer who is employed by or under contract with one of the following entities or who uses curriculum or training materials developed by or obtained with the written permission of one of the following entities:

- (1) An accredited university or college.
- (2) A community college.
- (3) Iowa State University Extension.
- (4) A child care resource and referral agency.
- (5) An area education agency.
- (6) The regents' center for early developmental education at the University of Northern Iowa.
- (7) A hospital (for health and safety, first-aid, and CPR training).
- (8) The American Red Cross, the American Heart Association, the National Safety Council, or Medic First Aid (for first-aid and CPR training).
- (9) An Iowa professional association, including the Iowa Association for the Education of Young Children (Iowa AEYC), the Iowa Family Child Care Association (IFCCA), the Iowa After School Alliance, and the Iowa Head Start Association.
- (10) A national professional association, including the National Association for the Education of Young Children (NAEYC), the National Child Care Association (NCCA), the National Association for Family Child Care (NAFCC), the National After School Association, and the American Academy of Pediatrics.
- (11) The Child and Adult Care Food Program and the Special Supplemental Nutrition Program for Women, Infants and Children (WIC).
- (12) The Iowa department of public health, department of education, or department of human services.
- (13) Head Start agencies or the Head Start technical assistance system.

b. Training received in a group setting must follow a presentation format that incorporates a variety of adult learning methods. The material or content of the training must be obtained from one of the entities listed in paragraph "a" or an entity approved under paragraph "g." Approved training shall be made available to Iowa child care providers through the child care provider training registry beginning July 1, 2009.

c. Training received in a group setting may include distance learning opportunities such as training conducted over the Iowa communications network, on-line courses, or Web conferencing (webinars) if:

- (1) The training meets the requirements in subrule 110.5(14);
- (2) The training is taught by an instructor and requires interaction between the instructor and the participants, such as required chats or message boards; and
- (3) The training organization meets the requirements listed in this subrule or is approved by the department.

d. The department will not approve more than eight hours of training delivered in a single day.

e. The department may randomly monitor any state-approved training for quality control purposes.

f. Training conducted with staff either during the hours of operation of the facility, staff lunch hours, or while children are resting must not diminish the required staff ratio coverage. Staff shall not be actively engaged in care and supervision and simultaneously participate in training.

g. A training organization not approved by the department may submit training for approval to the department on Form 470-4528, Request for Child Care Training Approval. All approvals, unless otherwise specified, shall be valid for five years. The department shall issue its decision within 30 business days of receipt of a complete request.

110.5(13) Self-study training. Up to six hours of training may be received in self-study using a training package approved by the department.

a. Self-study training packages approved by the department include curriculum developed and materials distributed by:

- (1) Department child care licensing consultants,
- (2) Iowa State University Extension, or
- (3) A child care resource and referral agency.

b. Self-study training materials not distributed by these entities may be submitted by the training organization to the department for approval on Form 470-4528, Request for Child Care Training Approval. All approvals, unless otherwise specified, shall be valid for five years. The department shall issue its decision within 30 business days of receipt of a complete request.

110.5(14) Approved training. Training provided to Iowa child care providers shall offer:

a. Instruction that is consistent with:

- (1) Iowa child care regulatory standards;
- (2) The Iowa early learning standards; and
- (3) The philosophy of developmentally appropriate practice as defined by the National Association for the Education of Young Children, the Program for Infant/Toddler Care, and the National Health and Safety Performance Standards.

b. Content equal to at least one contact hour of training.

c. An opportunity for ongoing interaction and timely feedback, including questions and answers within the contact hours if training is delivered in a group setting.

d. A certificate of training for each participant that includes:

- (1) The name of the participant.
- (2) The title of the training.
- (3) The dates of training.
- (4) The content area addressed.
- (5) The name of the training organization.
- (6) The name of the instructor.
- (7) The number of contact hours.
- (8) An indication of whether the training was delivered through self-study or in a group setting.

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441—110.6(237A) Compliance checks. During a calendar year, the department shall seek to check 100 percent of all child development homes in each county for compliance with registration requirements. Completed evaluation checklists shall be placed in the registration files.

[ARC 1637C, IAB 10/1/14, effective 1/1/15]

441—110.7(234) Registration decision. The department shall issue Form 470-3498, Certificate of Registration, when an applicant meets all requirements for registration. Each local office of the department shall maintain a current list of registered child development homes as a referral service to the community.

110.7(1) Registration shall be denied or revoked if the department finds a hazard to the safety and well-being of a child and the provider cannot correct or refuses to correct the hazard, even though the hazard may not have been specifically listed under the health and safety rules. Registration may also

be denied or revoked if the department determines that the provider has failed to comply with standards imposed by law and these rules.

110.7(2) Record shall be kept in an open file of all denials or revocations of registration and the documentation of reasons for denying or revoking the registration.

110.7(3) Record checks.

a. Applicability. The department shall conduct Iowa criminal history record and child abuse record checks for each registrant, substitute or staff member, anyone living in the home who is 14 years of age or older, and anyone having access to a child when the child is alone. The department shall conduct national criminal history record checks, based on fingerprints, for each registrant, substitute or staff member, anyone living in the home who is 18 years of age or older, and anyone 18 years of age or older having access to a child when the child is alone. In accordance with Iowa Code section 726.23, minors under the age of 18 will not be subject to the fingerprint requirement.

(1) The purpose of these record checks is to determine whether the person has committed a transgression that prohibits or limits the person's involvement with child care.

(2) The department may also conduct criminal history record and child abuse record checks in other states and may conduct dependent adult abuse, sex offender registry, and other public or civil offense record checks in Iowa or other states.

(3) Effective July 1, 2013, registration or renewal certificates shall not be issued until the results of all state and national record checks have been received and, when necessary, evaluated.

b. Authorization. The person subject to record checks shall complete Form 470-5143, Iowa Department of Human Services Record Check Authorization Form; Form DCI-45, Waiver Agreement; Form FD-258, Federal Fingerprint Card; and any other forms required by the department of public safety to authorize the release of records.

c. Iowa records checks. Checks and evaluations of Iowa child abuse and criminal history records shall be completed before the person's involvement with child care. Iowa records checks shall be repeated at a minimum of every two years and when the department or the registrant becomes aware of any possible transgressions. The department is responsible for the cost of conducting the Iowa records checks.

d. National criminal history record checks. Fingerprint-based checks of national criminal history records shall also be completed before a person's involvement with child care. This requirement shall be effective on or after July 1, 2013, for an initial application for registration or a renewal application for registration. The national criminal history record check shall be repeated for each person subject to the check every four years and when the department or registrant becomes aware of any new transgressions committed by that person in another state. The department is responsible for the cost of conducting the national criminal history record check.

(1) The registrant is responsible for any costs associated with the taking (rolling) of fingerprints of all persons subject to record checks and for submitting the prints to the department so the national criminal history record check can be completed. Fingerprints may be taken (rolled) by law enforcement agencies or by agencies or companies that specialize in taking (rolling) fingerprints.

(2) The department shall provide fingerprints to the department of public safety no later than ten business days after receipt of the fingerprint cards. The department shall submit the fingerprints on forms or in a manner allowed by the department of public safety.

(3) The department may rely on the results of previously conducted national criminal history record checks when a person subject to a record check in one child development home or child care home submits a request for involvement with child care in another child development home or child care home, so long as the person's national criminal history record check is within the allowable four-year time frame. All initial or new applications shall require a new national criminal history record check.

e. Mandatory prohibition. A person with any of the following convictions or founded abuse reports is prohibited from involvement with child care:

- (1) Founded child or dependent adult abuse that was determined to be sexual abuse.
- (2) Placement on the sex offender registry.
- (3) Felony child endangerment or neglect or abandonment of a dependent person.

- (4) Felony domestic abuse.
- (5) Felony crime against a child including, but not limited to, sexual exploitation of a minor.
- (6) Forcible felony.

f. Mandatory time-limited prohibition.

(1) A person with the following conviction or founded abuse report is prohibited from involvement with child care for five years from the date of the conviction or founded abuse report:

1. Conviction of a controlled substance offense under Iowa Code chapter 124.
2. Founded child abuse that was determined to be physical abuse.

(2) After the five-year prohibition period (from the date of the conviction or the founded abuse report) as defined in subparagraph 110.7(3) “f”(1), the person may request the department to perform an evaluation under paragraph 110.7(3) “g” to determine whether prohibition of the person’s involvement with child care continues to be warranted.

g. Evaluation required. For all other transgressions, and as requested under subparagraph 110.7(3) “f”(2), the department shall evaluate the transgression and make a decision about the person’s involvement with child care.

(1) The person with the transgression shall complete and return Form 470-2310, Record Check Evaluation, within ten calendar days of the date on the form. The department shall use the information the person with the transgression provides on this form to assist in the evaluation. Failure of the person with the transgression to complete and return this form within ten calendar days of the date on the form shall result in denial or revocation of the registration certificate.

(2) The department may use information from the department’s case records in performing the evaluation.

(3) In an evaluation, the department shall consider all of the following factors:

1. The nature and seriousness of the transgression in relation to the position sought or held.
2. The time elapsed since the commission of the transgression.
3. The circumstances under which the transgression was committed.
4. The degree of rehabilitation.
5. The likelihood that the person will commit the transgression again.
6. The number of transgressions committed by the person.

(4) When a person subject to a record check has a transgression that has been determined in a previous evaluation not to warrant prohibition of the person’s involvement with child care and the person has no subsequent transgressions, an exemption from reevaluation of the latest record check is authorized. The person may commence employment with another child care facility in accordance with the department’s previous evaluation. The exemption is subject to all of the following conditions:

1. The position with the subsequent employer is substantially the same or has the same job responsibilities as the position for which the previous evaluation was performed.

2. Any restrictions placed on the person’s employment by the department in the previous evaluation shall remain applicable in the person’s subsequent employment.

3. The person subject to the record check has maintained a copy of the previous evaluation and provides the evaluation to the subsequent employer or the previous employer provides to the subsequent employer the previous evaluation from the person’s personnel file pursuant to the person’s authorization. If a physical copy of the previous evaluation is not provided to the subsequent employer, the record check shall be reevaluated.

4. The subsequent employer may request a reevaluation of the record check and may employ the person while the reevaluation is being performed.

h. Evaluation decision. The department has final authority in determining whether prohibition of the person’s involvement with child care is warranted and in developing any conditional requirements or corrective action plan.

(1) Within 30 calendar days of receipt of a completed Form 470-2310, Record Check Evaluation, the department shall make a decision on the person’s involvement with child care.

(2) Within 30 calendar days of receipt of a completed Form 470-2310, Record Check Evaluation, the department shall mail to the person subject to an evaluation Form 470-2386, Record Check Decision,

that explains the decision reached regarding the evaluation of the transgression and Form 470-4558, Notice of Decision: Child Care.

(3) The department shall issue Form 470-4558, Notice of Decision: Child Care, prohibiting involvement with child care, when the person subject to an evaluation fails to complete the Record Check Evaluation, Form 470-2310, within the ten-calendar-day time frame.

(4) If the department determines, through the record check evaluation process, that the person's prohibition of involvement with child care is warranted, the person shall be prohibited from involvement with child care. The department may identify a period of time after which the person may request that another record check and evaluation be performed.

(5) The department may permit a person who is evaluated to maintain involvement with child care if the person complies with the department's conditions relating to the person's involvement with child care, which may include completion of additional training or an individually designed corrective action plan or both. For an employee of a registrant, these conditional requirements shall be developed with the registrant. All conditions placed on a person's involvement with child care shall be communicated, in writing, to both the person subject to the evaluation and the registrant.

i. Notice to parents of abuse in care. If there has been founded child abuse committed by an owner, director, or staff member of the child care facility or child care home, the department's administrator shall notify the parents, guardians, and legal custodians of each child for whom the facility or child care home provides care. The child care facility or child care home shall cooperate with the department in providing the names and addresses of the parents, guardians, and legal custodians of each child for whom the facility provides child care.

(1) The child care facility or child care home shall cooperate with the department in providing the names and addresses of the parent, guardian, or custodian of each child for whom the facility provides child care.

(2) This information shall be provided to the department within ten calendar days from the date of the initial request.

(3) Failure or refusal to provide the requested information may result in revocation of registration.

110.7(4) Letter of revocation. A letter received by an owner or operator of a child development home initiating action to deny or revoke the home's registration shall be conspicuously posted where it can be read by parents or any member of the public. The letter shall remain posted until resolution of the action to deny or revoke an owner's or operator's certificate of registration.

110.7(5) If the department has denied or revoked a registration because the provider has continually or repeatedly failed to operate in compliance with Iowa Code chapter 237A and 441—Chapter 110, the person shall not own or operate a registered facility for a period of 12 months from the date of denial or revocation. The department shall not act on an application for registration submitted by the applicant or provider during the 12-month period. The applicant shall be prohibited from involvement with child care unless the department specifically permits the involvement.

110.7(6) Required notifications. If a certificate of registration is revoked, the administrator of the department shall notify the parent, guardian, or legal custodian of each child for whom the facility provides care. The provider shall cooperate with the department in providing the names and address of the parent, guardian, or legal custodian of each child for whom the facility provides child care.

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441—110.8(237A) Additional requirements for child development home category A. In addition to the requirements in rule 441—110.5(237A), a provider requesting registration in child development home category A shall meet the following standards:

110.8(1) *Limits on number of children in care.*

a. No more than six children not attending kindergarten or a higher grade level shall be present at any one time.

b. Of these six children, not more than four children who are 24 months of age or younger shall be present at any one time. Of these four children, no more than three may be 18 months of age or younger.

c. In addition to the six children not in school, no more than two children who attend school may be present for a period of less than two hours at a time.

d. No more than eight children shall be present at any one time when an emergency school closing is in effect.

110.8(2) Provider qualifications.

a. The provider shall be at least 18 years old.

b. The provider shall have three written references which attest to character and ability to provide child care.

441—110.9(237A) Additional requirements for child development home category B. In addition to the requirements in rule 441—110.5(237A), a provider requesting registration in child development home category B shall meet the following standards:

110.9(1) Limits on number of children in care.

a. No more than six children not attending kindergarten or a higher grade level shall be present at any one time.

b. Of these six children, not more than four children who are 24 months of age or younger shall be present at any one time. Of these four children, no more than three may be 18 months of age or younger.

c. In addition to the six children not in school, no more than four children who attend school may be present.

d. In addition to these ten children, no more than two children who are receiving care on a part-time basis may be present.

e. No more than 12 children shall be present at any one time when an emergency school closing is in effect.

f. If more than eight children are present at any one time for a period of more than two hours, the provider shall be assisted by a department-approved assistant who is at least 14 years old.

110.9(2) Provider qualifications.

a. The provider shall be at least 20 years old.

b. The provider shall have a high school diploma or GED.

c. The provider shall either:

(1) Have two years of experience as a registered or nonregistered child care provider, or

(2) Have a child development associate credential or any two-year or four-year degree in a child-care-related field and one year of experience as a registered or nonregistered child care home provider.

110.9(3) Facility requirements.

a. The home shall have a minimum of 35 square feet of child-use floor space for each child in care indoors, and a minimum of 50 square feet per child in care outdoors.

b. The home shall have a separate quiet area for sick children.

c. The home shall have a minimum of two direct exits to the outside from the main floor.

(1) If the second level or the basement of the home is used for the provision of child care, other than the use of a restroom, each additional child-occupied floor shall have at least one direct exit to the outside in addition to one inside stairway.

(2) All exits shall terminate at grade level with permanent steps.

(3) A basement window may be used as an exit if the window can be opened from the inside without the use of tools and it provides a clear opening of not less than 20 inches in width, 24 inches in height, and 5.7 square feet in area. The bottom of the opening shall be not more than 44 inches above the floor, with permanent steps inside leading up to the window.

(4) Occupancy above the second floor shall not be permitted for child care.

441—110.10(237A) Additional requirements for child development home category C. In addition to the requirements in rule 441—110.5(237A), a provider requesting registration in child development home category C shall meet the following standards:

110.10(1) *Limits on number of children in care.*

- a. No more than 12 children not attending kindergarten or a higher grade level shall be present at any one time.
- b. Of these 12 children, not more than 4 children who are 24 months of age or younger shall be present at any one time. Whenever 4 children who are under the age of 18 months are in care, both providers shall be present.
- c. In addition to the 12 children not in school, no more than 2 children who attend school may be present for a period of less than two hours at any one time.
- d. In addition to these 14 children, no more than 2 children who are receiving care on a part-time basis may be present.
- e. No more than 16 children shall be present at any one time when an emergency school closing is in effect. If more than 8 children are present at any one time due to an emergency school closing exception, the provider shall be assisted by a department-approved assistant who is at least 18 years of age.
- f. If more than eight children are present, both providers shall be present. Each provider shall meet the provider qualifications for child development home category C.

110.10(2) *Provider qualifications.*

- a. One provider who meets the following qualifications must always be present:
 - (1) The provider shall be at least 21 years old.
 - (2) The provider shall have a high school diploma or GED.
 - (3) The provider shall either:
 1. Have five years of experience as a registered or nonregistered child care provider, or
 2. Have a child development associate credential or any two-year or four-year degree in a child care-related field and four years of experience as a registered or nonregistered child care home provider.
- b. The coprovider shall meet the requirements of subrule 110.9(2).

110.10(3) *Facility requirements.*

- a. The home shall have a minimum of 35 square feet of child-use floor space for each child in care indoors, and a minimum of 50 square feet per child in care outdoors.
- b. The home shall have a separate quiet area for sick children.
- c. The home shall have a minimum of two direct exits to the outside from the main floor.
 - (1) If the second level or the basement of the home is used for the provision of child care, other than the use of a restroom, each additional child-occupied floor shall have at least one direct exit to the outside in addition to one inside stairway.
 - (2) All exits shall terminate at grade level with permanent steps.
 - (3) A basement window may be used as an exit if the window can be opened from the inside without the use of tools and it provides a clear opening of not less than 20 inches in width, 24 inches in height, and 5.7 square feet in area. The bottom of the opening shall be not more than 44 inches above the floor, with permanent steps inside leading up to the window.
 - (4) Occupancy above the second floor shall not be permitted for child care.

441—110.11(237A) Complaints. The department shall conduct an on-site visit when a complaint is received.

110.11(1) After each complaint visit, the department shall document whether the child development home was in compliance with registration requirements.

110.11(2) The written documentation of the department's conclusion as to whether the child development home was in compliance with requirements shall be available to the public. However, the identity of all complainants shall be confidential, unless expressly waived by the complainant.

441—110.12(237A) Registration actions for nonpayment of child support. The department shall revoke or deny the issuance or renewal of a child development home registration upon the receipt of a certificate of noncompliance from the child support recovery unit of the department according to the

procedures in Iowa Code chapter 252J. In addition to the procedures set forth in Iowa Code chapter 252J, the rules in this chapter shall apply.

110.12(1) *Service of notice.* The notice required by Iowa Code section 252J.8 shall be served upon the applicant or registrant by restricted certified mail, return receipt requested, or personal service in accordance with Iowa Rules of Civil Procedure 56.1. Alternatively, the applicant or registrant may accept service personally or through authorized counsel.

110.12(2) *Effective date.* The effective date of the revocation or denial of the registration as specified in the notice required by Iowa Code section 252J.8 shall be 60 days following service of the notice upon the applicant or licensee.

110.12(3) *Preparation of notice.* The department director or designee of the director is authorized to prepare and serve the notice as required by Iowa Code section 252J.8 upon the applicant or registrant.

110.12(4) *Responsibilities of registrants and applicants.* Registrants and registrant applicants shall keep the department informed of all court actions, and all child support recovery unit actions taken under or in connection with Iowa Code chapter 252J, and shall provide the department copies, within seven days of filing or issuance, of all applications filed with the district court pursuant to Iowa Code section 252J.9, all court orders entered in the actions, and withdrawals of certificates of noncompliance by the child support recovery unit.

110.12(5) *District court.* A registrant or applicant may file an application with the district court within 30 days of service of a department notice pursuant to Iowa Code sections 252J.8 and 252J.9.

a. The filing of the application shall stay the department action until the department receives a court order lifting the stay, dismissing the action, or otherwise directing the department to proceed.

b. For purposes of determining the effective date of the revocation, or denial of the issuance or renewal of a registration, the department shall count the number of days before the action was filed and the number of days after the action was disposed of by the court.

110.12(6) *Procedure for notification.* The department shall notify the applicant or registrant in writing through regular first-class mail, or such other means as the department deems appropriate in the circumstances, within ten days of the effective date of the revocation of a registration or the denial of the issuance or renewal of a registration, and shall similarly notify the applicant or registrant when the registration is issued, renewed, or reinstated following the department's receipt of a withdrawal of the certificate of noncompliance.

110.12(7) *Appeal rights.* Notwithstanding Iowa Code section 17A.18, the registrant does not have the right to a hearing regarding this issue, but may request a court hearing pursuant to Iowa Code section 252J.9.

441—110.13(237A) Transition exception. The following transition exceptions shall apply to providers renewing a valid previously issued child care home registration on or after December 1, 2002:

110.13(1) If the provider is providing child care to four infants at the time of renewal, the provider may continue to provide child care to those four infants. However, when the provider no longer provides child care to one or more of the four infants, or one or more of the four infants reaches the age of 24 months, this exception shall no longer apply. This exception does not affect the overall limit on the number of children in care under the child development home category within which the provider is registered.

110.13(2) If the provider is providing child care to school-age children in excess of the number allowable for the provider's registration category at the time of renewal, the provider may continue to provide care to those children and may exceed the total number of children authorized for that category by the excess number of school-age children. This exception is subject to the following conditions:

a. The maximum number of children attributable to this exception is five.

b. The provider must comply with the other requirements limiting the number of children under that registration category.

c. If more than eight children are present at any one time for more than two hours, the provider shall be assisted by a department-approved assistant who is at least 14 years of age.

d. When the provider no longer provides child care to one or more of the school-age children who was receiving child care at the time of registration, the excess number of children allowed under this exception shall be reduced accordingly.

441—110.14(237A) Prohibition from involvement with child care. If the department has prohibited a person or program from involvement with child care, that person or program shall not provide child care as a nonregistered child care home provider.

These rules are intended to implement Iowa Code section 234.6 and chapter 237A.

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481—67.1(231B,231C,231D) Definitions. The following definitions apply to this chapter and to 481—Chapters 68, 69, and 70.

“Activities of daily living” means the following self-care tasks: bathing, dressing, grooming, eating, transferring, toileting, and ambulation.

“Ambulatory” or *“ambulation”* means physically and cognitively able to walk without aid of another person.

“Applicable requirements” means Iowa Code chapters 135C, 231B, 231C, 231D, 235B, 235E, and 562A, this chapter, and 481—Chapters 68, 69, and 70, as applicable, and includes any other applicable administrative rules and provisions of the Iowa Code.

“Applicant or certificate holder” means the owner and operator of a program. If a program is operated under an operating agreement, both the owner and the operator are the applicant or certificate holder. If a program is leased, the lessee is the applicant or certificate holder.

“Assignment” means the distribution of work for which each staff member, regardless of certification or licensure status, is responsible during a given work period and includes a nurse directing an individual to do something the individual is already authorized to do.

“Assistance” means aid to a tenant who self-directs or participates in a task or activity or who retains the mental or physical ability, or both, to participate in a task or activity. Cueing of the tenant regarding a particular task or activity shall be construed to mean the tenant has participated in the task or activity.

“Blueprint” means copies of all completed drawings, schedules, and specifications that have been certified, sealed, and signed by an Iowa-licensed architect or Iowa-licensed engineer of record. The department may allow electronic transfer of blueprints pursuant to policy.

“Certified staff” means certified nursing assistants (CNAs) and certified medication assistants (CMAs) employed by the program.

“Dementia” means an illness characterized by multiple cognitive deficits which represent a decline from previous levels of functioning and includes memory impairment and one or more of the following cognitive disturbances: aphasia, apraxia, agnosia, and disturbance in executive functioning.

“Department” means the department of inspections and appeals.

“Director” means the director of the department of inspections and appeals.

“Direct supervision” means the provision of guidance and oversight of a delegated nursing task through the physical presence of the licensed nurse to observe and direct certified and noncertified staff.

“Elope” means that a tenant who has impaired decision-making ability leaves the program without the knowledge or authorization of staff.

“Global Deterioration Scale” or *“GDS”* means the seven-stage scale for assessment of primary degenerative dementia developed by Dr. Barry Reisberg.

“Health care professional” means a physician, physician assistant, registered nurse or advanced registered nurse practitioner licensed in Iowa by the respective licensing board.

“Health-related care” means services provided by a registered nurse or a licensed practical nurse, on a part-time or intermittent basis, and services provided by other licensed health care professionals, on a part-time or intermittent basis. “Health-related care” includes nurse-delegated assistance.

“Human service professional” means an individual with a bachelor’s degree in a human service field including, but not limited to: human services, gerontology, social work, sociology, psychology, or family science. Two years of experience in a human service field may be substituted for up to two years of the required education. For example, an individual with an associate’s degree in a human service field and two years of experience in a human service field is a human service professional.

“Impaired decision-making ability” means a lack of capacity to make safe and prudent decisions regarding one’s own routine safety as determined by the program manager or nurse or means having a GDS score of four or above.

“Independent reviewer” means an attorney licensed in the state of Iowa who is not currently and has not been employed by the department in the past eight years, or has not appeared in front of the department on behalf of a health care facility in the past eight years. Preference shall be given to an attorney with background knowledge, experience or training in long-term care.

“Indirect supervision” means the provision of guidance and oversight of a delegated nursing task through means other than direct supervision, including written and verbal communication.

“Instrumental activities of daily living” means those activities that reflect the tenant’s ability to perform household and other tasks necessary to meet the tenant’s needs within the community, which may include but are not limited to shopping, housekeeping, chores, and traveling within the community.

“Medication setup” means assistance with various steps of medication administration to support a tenant’s autonomy, which may include but is not limited to routine prompting, cueing and reminding, opening containers or packaging at the direction of the tenant, reading instructions or other label information, or transferring medications from the original containers into suitable medication dispensing containers, reminder containers, or medication cups.

“Modification” means any addition to or change in physical dimensions or structure, except as incidental to the customary maintenance of the physical structure of the program’s facility.

“Monitoring” means an on-site evaluation of a program, a complaint investigation, or a program-reported incident investigation performed by the department to determine compliance with applicable requirements. A monitor who performs a monitoring for the department shall be a registered nurse, human service professional, or another person with program-related expertise.

“Noncertified staff” means unlicensed and uncertified personnel employed by the program.

“Nurse delegation” means the action of a registered nurse, advanced registered nurse practitioner, or licensed practical nurse to direct competent certified and noncertified staff to perform selected nursing tasks in selected situations. The decision of a nurse to delegate is based on the delegation process, including assessment, planning, implementation, supervision, and evaluation of the tenant, nursing tasks, personnel, and the situation. The nurse, as a licensed professional, retains accountability for the delegation process and the decision to delegate. Licensed practical nurses may delegate within the scope of their license with the supervision of a registered nurse.

“Occupancy agreement” or *“contractual agreement”* means a written contract entered into between a program and a tenant that clearly describes the rights and responsibilities of the program and the tenant and other information required by applicable requirements. An occupancy agreement may include a separate signed lease and signed service agreement.

“Part-time or intermittent care” means licensed nursing services and professional therapies that are provided no more than 5 days per week; or licensed nursing services and professional therapies that are provided 6 or 7 days per week for a temporary period of time with a predictable end within 21 days; or licensed nursing services and professional therapies that do not exceed 28 hours per week or, for adult day services, 4 hours per day and are provided in combination with nurse-delegated assistance with medications or activities of daily living.

“Personal care” means assistance with the essential activities of daily living which may include but are not limited to transferring, bathing, personal hygiene, dressing, and grooming that are essential to the health and welfare of a tenant.

“Physician extender” means nurse practitioners, clinical nurse specialists, and physician assistants.

“Preponderance of the evidence” means that the evidence, considered and compared with the evidence opposed to it, produces the belief in a reasonable mind that the allegations are more likely true than not true.

“Program” means one or more of the following, as applicable: an elder group home as defined in Iowa Code section 231B.1 and 481—Chapter 68, an assisted living program as defined in Iowa Code section 231C.1 and 481—Chapter 69, or adult day services as defined in Iowa Code section 231D.1 and 481—Chapter 70.

“Program staff” means all employees of the program, regardless of certification or licensure status.

“Qualified professional” means a facility plant engineer familiar with the type of program being provided, or a licensed plumbing, heating, cooling, or electrical contractor who furnishes regular service to such equipment.

“Recognized accrediting entity” means a nationally recognized accrediting entity that the department recognizes as having specific program standards equivalent to the program standards established by the department.

“Regulatory insufficiency” means a violation of an applicable requirement.

“Remodeling” means a modification of any part of an existing building, an addition of a new wing or floor to an existing building, or a conversion of an existing building.

“Routine” means more often than not or on a regular customary basis.

“Self-administration” means a tenant’s taking personal responsibility for all phases of medication except for any component assigned to the program under medication setup, and may include the tenant’s use of an automatic pill dispenser.

“Service plan” means the document that defines all services necessary to meet the needs and preferences of a tenant, whether or not the services are provided by the program or other service providers.

“Significant change” means a major decline or improvement in the tenant’s status which does not normally resolve itself without further interventions by staff or by implementing standard disease-related clinical interventions that have an impact on the tenant’s mental, physical, or functional health status.

“Substantial compliance” means a level of compliance with applicable requirements such that any identified regulatory insufficiency poses no greater risk to tenant health or safety than the potential for causing minimal harm.

“Tenant” means an individual who receives services through a program. In the context of adult day services, “tenant” means a participant as defined in 481—Chapter 70.

“Tenant advocate” means the office of long-term care resident’s advocate established in Iowa Code section 231.42.

“Tenant’s legal representative” means a person appointed by the court to act on behalf of a tenant or a person acting pursuant to a power of attorney. In the context of adult day services, “tenant’s legal representative” means a participant’s legal representative as defined in 481—Chapter 70.

“Waiver” means action taken by the department that suspends in whole or in part the requirements or provisions of a rule.

[ARC 8174B, IAB 9/23/09, effective 1/1/10; ARC 0961C, IAB 8/21/13, effective 9/25/13; ARC 1055C, IAB 10/2/13, effective 1/1/14]

481—67.2(231B,231C,231D) Program policies and procedures, including those for incident reports. A program’s policies and procedures must meet the minimum standards set by applicable requirements. The program shall follow the policies and procedures established by a program. All programs shall have policies and procedures related to the reporting of incidents including allegations of dependent adult abuse.

67.2(1) The program’s policies and procedures on incident reports, at a minimum, shall include the following:

- a. The program shall have available incident report forms for use by program staff.
- b. An incident report shall be in detail and shall be provided on an incident report form.
- c. The person in charge at the time of the incident shall prepare and sign the report.
- d. The incident report shall include statements from individuals, if any, who witnessed the incident.
- e. All accidents or unusual occurrences within the program’s building or on the premises that affect tenants shall be reported as incidents.
- f. A copy of the completed incident report shall be kept on file on the program’s premises for a minimum of three years.

67.2(2) The program’s policies and procedures on allegations of dependent adult abuse shall be consistent with Iowa Code chapter 235E and rules adopted pursuant to that chapter and, at a minimum, shall include:

- a. Reporting requirements for staff and employees, and
- b. Requirements that the victim and alleged abuser be separated.

[ARC 8174B, IAB 9/23/09, effective 1/1/10]

481—67.3(231B,231C,231D) Tenant rights. All tenants have the following rights:

67.3(1) To be treated with consideration, respect, and full recognition of personal dignity and autonomy.

67.3(2) To receive care, treatment and services which are adequate and appropriate.

67.3(3) To receive respect and privacy in the tenant's medical care program. Personal and medical records shall be confidential, and the written consent of the tenant shall be obtained for the records' release to any individual, including family members, except as needed in case of the tenant's transfer to a health care facility or as required by law or a third-party payment contract.

67.3(4) To be free from mental and physical abuse.

67.3(5) To receive from the manager and staff of the program a reasonable response to all requests.

67.3(6) To associate and communicate privately and without restriction with persons and groups of the tenant's choice, including the tenant advocate, on the tenant's initiative or on the initiative of the persons or groups at any reasonable hour.

67.3(7) To manage the tenant's own financial affairs unless a tenant's legal representative has been appointed for the purpose of managing the tenant's financial affairs.

67.3(8) To present grievances and recommend changes in program policies and services, personally or through other persons or in combination with others, to the program's staff or person in charge without fear of reprisal, restraint, interference, coercion, or discrimination.

[ARC 8174B, IAB 9/23/09, effective 1/1/10]

481—67.4(231B,231C,231D) Program notification to the department. The director or the director's designee shall be notified within 24 hours, or the next business day, by the most expeditious means available:

67.4(1) Of any accident causing major injury. For the purposes of this rule, "major injury" shall also mean a substantial injury.

a. "Major injury" shall be defined as any injury which:

- (1) Results in death; or
- (2) Requires admission to a higher level of care for treatment, other than for observation; or
- (3) Requires consultation with the attending physician, designee of the physician, or physician extender who determines, in writing on a form designated by the department, that an injury is a "major injury" based upon the circumstances of the accident, the previous functional ability of the tenant, and the tenant's prognosis.

b. The following are not reportable accidents:

- (1) An ambulatory tenant who falls when neither the program nor its employees have culpability related to the fall, even if the tenant sustains a major injury; or
- (2) Spontaneous fractures; or
- (3) Hairline fractures.

67.4(2) When damage to the program is caused by a natural or other disaster.

67.4(3) When there is an act that causes major injury to a tenant or when a program has knowledge of a pattern of acts committed by the same tenant on another tenant that results in any physical injury. For the purposes of this subrule, "pattern" means two or more times within a 30-day period.

67.4(4) When a tenant elopes from a program.

67.4(5) When a tenant attempts suicide, regardless of injury.

67.4(6) When a fire occurs in a program and the fire requires the notification of emergency services, requires full or partial evacuation of the program, or causes physical injury to a tenant.

67.4(7) When a defect or failure occurs in the fire sprinkler or fire alarm system for more than 4 hours in a 24-hour period. (This reporting requirement is in addition to the requirement to notify the state fire marshal.)

NOTE: Additional reporting requirements are created by other rules and statutes, including but not limited to Iowa Code chapters 235B and 235E, which require reporting of dependent adult abuse.
[ARC 8174B, IAB 9/23/09, effective 1/1/10]

481—67.5(231B,231C,231D) Medications. Each program shall follow its own written medication policy, which shall include the following:

67.5(1) The program shall not prohibit a tenant from self-administering medications.

67.5(2) A tenant shall self-administer medications unless:

a. The tenant or the tenant's legal representative delegates in the occupancy agreement or signed service plan any portion of medication setup to the program.

b. The tenant delegates medication setup to someone other than the program.

c. The program assumes partial control of medication setup at the direction of the tenant. The medication plan shall not be implemented by the program unless the program's registered nurse deems it appropriate under applicable requirements, including those in Iowa Code section 231C.16A and subrule 67.9(4). The program's registered nurse must agree to the medication plan.

67.5(3) A tenant shall keep medications in the tenant's possession unless the tenant or the tenant's legal representative, if applicable, delegates in the occupancy agreement or signed service plan partial or complete control of medications to the program. The service plan shall include the tenant's choice related to storage.

67.5(4) When a tenant has delegated medication administration to the program, the program shall maintain a list of the tenant's medications. If the tenant self-administers medications, the tenant may choose to maintain a list of medications in the tenant's apartment or to disclose a current list of medications to the program for the purpose of emergency response. If the tenant discloses a medication list to the program in case of an emergency, the tenant remains responsible for the accuracy of the list.

67.5(5) When medication setup is delegated to the program by the tenant, staff via nurse delegation may transfer medications from the original prescription containers or unit dosing into medication reminder boxes or medication cups.

67.5(6) When medications are administered traditionally by the program:

a. The administration of medications shall be provided by a registered nurse, licensed practical nurse or advanced registered nurse practitioner registered in Iowa or by certified and noncertified staff in accordance with subrule 67.9(4) or a physician assistant (PA) in accordance with 645—Chapter 327. Injectable medications shall be administered as permitted by Iowa law by a registered nurse, licensed practical nurse, advanced registered nurse practitioner, physician, pharmacist, or physician assistant (PA).

b. Medications shall be kept in a locked place or container that is not accessible to persons other than employees responsible for the administration or storage of such medications.

c. The program shall maintain a list of each tenant's medications and document the medications administered.

67.5(7) Narcotics protocol shall be determined by the program's registered nurse.

[ARC 8174B, IAB 9/23/09, effective 1/1/10; ARC 0961C, IAB 8/21/13, effective 9/25/13; ARC 1050C, IAB 10/2/13, effective 11/6/13]

481—67.6(231B,231C,231D) Another business or activity located in a program.

67.6(1) A business or activity serving persons other than tenants of a program is allowed in a designated part of the physical structure in which the program is located if the other business or activity meets the requirements of applicable state and federal codes, administrative rules, and federal regulations.

67.6(2) A business or activity conducted in the designated part of the physical structure in which the program is located shall not interfere with the use of the program by tenants or with services provided to tenants or disturb tenants.

67.6(3) A business or activity conducted in the designated part of the physical structure in which the program is located shall not reduce access, space, services, or staff available to tenants or necessary to meet the needs of tenants.

[ARC 8174B, IAB 9/23/09, effective 1/1/10]

481—67.7(231B,231C,231D) Waiver of criteria for retention of a tenant in the program.

67.7(1) *Time-limited waiver.* Upon receipt of a program's request for waiver of the criteria for retention of a tenant, the department may grant a waiver of the criteria under applicable requirements for a time-limited basis. Absent extenuating circumstances, a waiver of the criteria for retention of a tenant is limited to a period of six months or less.

67.7(2) *Waiver petition procedures.* The following procedures shall be used to request and to receive approval of a waiver from criteria for the retention of a tenant:

a. A program shall submit the waiver request on a form and in a manner designated by the department as soon as it becomes apparent that a tenant exceeds retention criteria pursuant to an evaluation by a health care or human service professional.

b. The department shall respond in writing to a waiver request within 15 working days of receipt of all required documentation. In consultation with the program, the department may take an additional 15 working days to report its determination regarding the waiver request.

c. The program shall provide to the department within 5 working days written notification of any changes in the condition of the tenant as described in the approved waiver request.

67.7(3) *Factors for consideration for waiver of criteria for retention of a tenant.* In addition to the criteria established in Iowa Code subsection 17A.9A(2), the following factors may be demonstrative in determining whether the criteria for issuance of a waiver have been met.

a. It is the informed choice of the tenant or the tenant's legal representative, if applicable, to remain in the program;

b. The program is able to provide the staff necessary to meet the tenant's service needs in addition to the service needs of the other tenants;

c. The department shall only issue a waiver if the waiver will not jeopardize the health, safety, security or welfare of the tenant, program staff, or other tenants; and

d. The tenant has been diagnosed with a terminal illness and has been admitted to hospice, and the tenant exceeds the criteria for retention and admission for a temporary period of less than six months. A terminal diagnosis means the tenant is within six months of the end of life.

67.7(4) *Conditional waiver.* A conditional waiver may be granted contingent upon the department's receipt of additional information or performance of monitoring.

a. If a waiver has been in effect for six months, a monitoring shall be conducted to determine whether the tenant meets the criteria to continue on a waiver.

b. The department may seek additional information during the period to determine if a waiver should be granted.

[ARC 8174B, IAB 9/23/09, effective 1/1/10]

481—67.8(231B,231C,231D) All other waiver requests. Waiver requests relating to topics other than retention of a tenant in a program shall be filed in accordance with 481—Chapter 6.

[ARC 8174B, IAB 9/23/09, effective 1/1/10]

481—67.9(231B,231C,231D) Staffing.

67.9(1) *Number of staff.* A sufficient number of trained staff shall be available at all times to fully meet tenants' identified needs.

67.9(2) *Emergency procedures.* All program staff shall be able to implement the accident, fire safety, and emergency procedures.

67.9(3) *Training documentation.* The program shall have training records and staffing schedules on file and shall maintain documentation of training received by program staff, including training of certified and noncertified staff on nurse-delegated procedures.

67.9(4) *Nurse delegation procedures.* The program's registered nurse shall ensure certified and noncertified staff are competent to meet the individual needs of tenants. Nurse delegation shall, at a minimum, include the following:

a. The program's newly hired registered nurse shall within 60 days of beginning employment as the program's registered nurse document a review to ensure that staff are sufficiently trained and competent in all tasks that are assigned or delegated.

b. Within 30 days of beginning employment, all program staff shall receive training by the program's registered nurse(s).

c. Training for noncertified staff shall include, at a minimum, the provision of activities of daily living and instrumental activities of daily living.

d. Certified and noncertified staff shall receive training regarding service plan tasks (e.g., wound care, pain management, rehabilitation needs and hospice care) in accordance with medical or nursing directives and the acuity of the tenants' health, cognitive or functional status.

e. The program's registered nurse(s) shall provide direct or indirect supervision of all certified and noncertified staff as necessary in the professional judgment of the program's registered nurse and in accordance with the needs of the tenants and certified and noncertified staff.

f. Services shall be provided to tenants in accordance with the training provided.

g. The program shall have in place a system by which certified or noncertified staff communicate in writing occurrences that differ from the tenant's normal health, functional and cognitive status. The program's registered nurse or designee shall train certified and noncertified staff on reporting to the program's registered nurse or designee and documenting occurrences that differ from the tenant's normal health, functional and cognitive status. The written communication required by this paragraph shall be retained by the program for a period of not less than three years, and shall be accessible to the department upon request.

h. In the absence of the program's registered nurse due to vacation or other temporary circumstances, the nurse assuming the duties of the program's registered nurse shall have access to staff training in relation to tenant needs.

67.9(5) *Prohibited services.* A program staff member shall not be designated as attorney-in-fact, guardian, conservator, or representative payee for a tenant unless the program staff member is related to the tenant by blood, marriage, or adoption.

[ARC 8174B, IAB 9/23/09, effective 1/1/10; ARC 0961C, IAB 8/21/13, effective 9/25/13; ARC 0963C, IAB 8/21/13, effective 9/25/13]

481—67.10(17A,231B,231C,231D) Monitoring.

67.10(1) *Frequency of monitoring.* The department shall monitor a certified program at least once during the program's certification period.

67.10(2) *Accessibility of records and program areas.* All records and areas of the program deemed necessary to determine compliance with the applicable requirements shall be accessible to the department for purposes of monitoring.

67.10(3) *Standard for determining whether a regulatory insufficiency exists.* The department shall use a preponderance-of-the-evidence standard when determining whether a regulatory insufficiency exists. A preponderance-of-the-evidence standard does not require that the monitor shall have personally witnessed the alleged violation.

[ARC 8174B, IAB 9/23/09, effective 1/1/10; ARC 1055C, IAB 10/2/13, effective 1/1/14]

481—67.11(231B,231C,231D) Complaint and program-reported incident report investigation procedure.

67.11(1) *Complaints.* The process for filing a complaint is as follows:

a. Any person with concerns regarding the operation or service delivery of a program may file a complaint with the Department of Inspections and Appeals, Complaints Unit, Lucas State Office Building, Third Floor, 321 E. 12th Street, Des Moines, Iowa 50319-0083; by use of the complaint hotline, 1-877-686-0027; by facsimile sent to (515)281-7106; or through the Web site address: https://dia-hfd.iowa.gov/DIA_HFD/Home.do.

b. When the nature of the complaint is outside the department's authority, the department shall forward the complaint or refer the complainant, if known, to the appropriate investigatory entity.

c. The complainant shall include as much of the following information as possible in the complaint: the complainant's name, address and telephone number; the complainant's relationship to the program or tenant; and the reason for the complaint. The complainant's name shall be confidential information and shall not be released by the department. The department shall act on anonymous complaints unless the department determines that the complaint is intended to harass the program. If the department, upon preliminary review, determines that the complaint is intended as harassment or is without reasonable basis, the department may dismiss the complaint.

67.11(2) *Program-reported incident reports.* When the program is required pursuant to applicable requirements to report an incident, the program shall make the report to the department via:

a. The Web-based reporting tool accessible from the following Internet site, https://dia-hfd.iowa.gov/DIA_HFD/Home.do, under the "Complaints" tab;

b. Mail by sending the complaint to the Department of Inspections and Appeals, Complaints Unit, Lucas State Office Building, Third Floor, 321 E. 12th Street, Des Moines, Iowa 50319-0083;

c. The complaint hotline, 1-877-686-0027; or

d. Facsimile sent to (515)281-7106.

67.11(3) *Time frames for investigation of complaints or program-reported incident reports.* Upon receipt of a complaint or program-reported incident report made in accordance with this rule, the department shall conduct a preliminary review of the complaint or report to determine if a potential regulatory insufficiency has occurred. If a potential regulatory insufficiency exists, the department shall institute a monitoring of the program within 20 working days unless there is the possibility of immediate danger, in which case the department shall institute a monitoring of the program within 2 working days of receipt of the complaint or incident report.

67.11(4) *Standard for determining whether a complaint is substantiated.* The department shall apply a preponderance-of-the-evidence standard in determining whether or not a complaint or program-reported incident report is substantiated.

67.11(5) *Notification of program and complainant.* The department shall notify the program and, if known, the complainant of the final report regarding the complaint investigation.

67.11(6) *Notification of accrediting entity.* In addition, for any credible report of alleged improper or inappropriate conduct or conditions within an accredited program, the department shall notify the accrediting entity by the most expeditious means possible of any actions taken by the department with respect to certification enforcement.

67.11(7) *Notification of complainant when complaint not investigated.* The department shall notify the complainant, if known, if the department does not investigate a complaint. The reasons for not investigating the complaint shall be included in the notification.

[ARC 8174B, IAB 9/23/09, effective 1/1/10; ARC 1055C, IAB 10/2/13, effective 1/1/14]

481—67.12(17A,231B,231D) Adult day services and elder group homes—preliminary report, plan of correction and request for reconsideration. Rescinded ARC 1701C, IAB 10/29/14, effective 1/1/15.

481—67.13(17A,231B,231C,231D,85GA,HF2365) Exit interview, final report, plan of correction.

67.13(1) *Exit interview.* The department shall provide an exit interview in person or by telephone at the conclusion of a monitoring, during which the department shall inform the program's representative of all issues and areas of concern related to insufficient practices. A second exit interview shall be provided if the department identifies additional issues or areas of concern. The program shall have 2 working days from the date of the exit interview to submit additional or rebuttal information to the department.

67.13(2) *Final report.* The department shall issue the final report of a monitoring within 10 working days after completion of the on-site monitoring or the receipt by the department of additional or rebuttal information, by personal service, electronically or by certified mail. The department shall issue a final report regarding a monitoring whether or not any regulatory insufficiency is found.

67.13(3) *Plan of correction.* Within 10 working days following receipt of the final report, the program shall submit a plan of correction to the department.

a. Contents of plan. The plan of correction shall include:

- (1) Elements detailing how the program will correct each regulatory insufficiency;
- (2) The date by which the regulatory insufficiency will be corrected;
- (3) What measures will be taken to ensure the problem does not recur;
- (4) How the program plans to monitor performance to ensure compliance; and
- (5) Any other required information.

The date by which the regulatory insufficiency will be corrected shall not exceed 30 days from receipt of the final report pursuant to subrule 67.13(2) without approval of the department.

b. Review of plan. The department shall review the plan of correction within 10 working days. The department may request additional information or suggest revisions to the plan.

67.13(4) *Monitoring revisit.* The department may conduct a monitoring revisit to ensure that the plan of correction has been implemented and the regulatory insufficiency has been corrected. The department may issue a regulatory insufficiency for failure to implement the plan of correction. A monitoring revisit by the department shall review the program prospectively from the date of the plan of correction to determine compliance.

[ARC 8174B, IAB 9/23/09, effective 1/1/10; ARC 1055C, IAB 10/2/13, effective 1/1/14; ARC 1701C, IAB 10/29/14, effective 1/1/15]

481—67.14(17A,231B,231C,231D,85GA,HF2365) Response to final report. Within 20 working days after the issuance of the final report and assessment of civil penalty, if any, the program shall respond in the following manner.

67.14(1) *If not contesting final report.* If the program does not desire to seek an informal conference or contest the final report and civil penalty, if assessed, the program shall remit to the department of inspections and appeals the amount of the civil penalty, if assessed. If a program has been assessed a civil penalty, the civil penalty shall be reduced by 35 percent if the requirements of subrule 67.17(5) are met.

67.14(2) *Informal conference.* If the program desires to contest the final report and civil penalty, if assessed, and request an informal conference, the program shall notify the department of inspections and appeals in writing that it desires to contest the final report and civil penalty and request in writing an informal conference with an independent reviewer.

a. Request for informal conference. The request for an informal conference must be in writing and include the following:

- (1) Identification of the regulatory insufficiency(ies) being disputed;
- (2) The type of informal conference requested: face-to-face or telephone conference; and
- (3) A request for monitor's notes for the regulatory insufficiencies being disputed, if desired.

b. Submission of documentation. The program shall submit the following within 10 working days from the date of the program's written request for an informal conference:

- (1) The names of those who will be attending the informal conference, including legal counsel; and
- (2) Documentation supporting the program's position. The program must highlight or use some other means to identify written information pertinent to the disputed regulatory insufficiency(ies). Supporting documentation that is not submitted with the request for an informal conference will not be considered, except as otherwise permitted by the independent reviewer upon good cause shown. "Good cause" means substantial or adequate grounds for failing to submit documentation in a timely manner. In determining whether the program has shown good cause, the independent reviewer shall consider what circumstances kept the program from submitting the supporting documentation within the required time frame.

c. Face-to-face or telephone conference. A face-to-face or telephone conference, if requested, will be scheduled to occur within 10 working days of the receipt of the written request, all supporting documentation and the plan of correction required by subrule 67.13(3).

- (1) Failure to submit supporting documentation will not delay scheduling.

(2) The conference will be scheduled for one hour. The program will informally present information and explanation concerning the contested regulatory insufficiency(ies). The department will have time to respond to the program's presentation. Due to the confidential nature of the conference, attendance may be limited.

(3) If additional information is requested by the independent reviewer during the informal conference, the program will have 2 working days to deliver the additional materials to the independent reviewer.

(4) When extenuating circumstances preclude a face-to-face conference, a telephone conference will be held or the program may be given one opportunity to reschedule the face-to-face conference.

d. Results. The results of the informal conference will generally be sent within 10 working days after the date of the informal conference, or within 10 working days after the receipt of additional information, if requested.

(1) The independent reviewer may affirm or may modify or dismiss the regulatory insufficiency and civil penalty. The independent reviewer shall state in writing the specific reasons for the affirmation, modification or dismissal of the regulatory insufficiency.

(2) The department will issue an amended (changes in factual content) or corrected (changes in typographical/data errors) final report if changes result from the informal conference.

(3) The program must submit to the department a new plan of correction for the amended or corrected report within 10 calendar days from the date of the letter conveying the results of the conference.

(4) If the informal conference results in dismissal of a regulatory insufficiency for which a civil penalty was assessed, the corresponding civil penalty will be rescinded.

67.14(3) *Procedure after informal conference.* After the conclusion of an informal conference:

a. If the program does not desire to further contest an affirmed or modified final report, the program shall, within 5 working days after receipt of the written decision of the independent reviewer, remit to the department of inspections and appeals the civil penalty, if assessed.

b. If the program does desire to further contest an affirmed or modified final report, the program shall, within 5 working days after receipt of the written decision of the independent reviewer, notify the department of inspections and appeals in writing that it desires to formally contest the final report.

67.14(4) *Appeals.* Formal hearings shall be conducted by the administrative hearings division pursuant to Iowa Code chapter 17A and 481—Chapter 10.

[ARC 8174B, IAB 9/23/09, effective 1/1/10; ARC 1055C, IAB 10/2/13, effective 1/1/14; ARC 1701C, IAB 10/29/14, effective 1/1/15]

481—67.15(17A,231B,231C,231D) Denial, suspension or revocation of a certificate.

67.15(1) *Notice and request for hearing.* The denial, suspension or revocation of a certificate shall be effected by delivering to the applicant or certificate holder by restricted certified mail or by personal service a notice setting forth the particular reasons for such actions. A denial, suspension or revocation shall be effective 30 days after certified mailing or personal service of the notice, unless the applicant or certificate holder gives the department written notice requesting a hearing within the 30-day period. If a timely request for hearing is made, the notice shall be deemed suspended pending the outcome of the hearing, unless subrule 67.15(3) or 67.15(4) applies. If an enforcement action has been implemented immediately in accordance with subrule 67.15(3) or 67.15(4), the enforcement action remains in effect regardless of a request for hearing.

67.15(2) *Hearings.* Hearings shall be conducted by the administrative hearings division of the department of inspections and appeals pursuant to Iowa Code chapter 17A and 481—Chapter 10.

67.15(3) *Immediate suspension of a certificate.* When the department finds that an imminent danger to the health or safety of tenants of a program exists which requires action on an emergency basis, the department may direct removal of all tenants from the program and suspend the certificate or require additional remedies to ensure the ongoing safety of the program's tenants prior to a hearing.

67.15(4) *Immediate imposition of enforcement action.* When the department finds that an imminent danger to the health or safety of tenants exists which requires action on an emergency basis, the department may immediately impose a conditional certificate and accompanying conditions upon the

program in lieu of immediate suspension of the certificate and removal of the tenants from the program if the department finds that tenants' health and safety would still be protected. The program may request a hearing, but the immediate enforcement action remains in effect regardless of the request for hearing. [ARC 1055C, IAB 10/2/13, effective 1/1/14]

481—67.16(17A,231B,231C,231D) Conditional certification.

67.16(1) Conditional certification. In lieu of denial, suspension or revocation of a certificate, the department may issue a conditional certificate for a period of up to one year. Notwithstanding subrule 67.15(4), a conditional certificate shall be issued only when regulatory insufficiencies pose no greater risk to tenant health or safety than the potential for causing minimal harm.

a. The department shall specify the reasons for the conditional certificate in the notice issuing the conditional certificate.

b. The department may place conditions upon a certificate, such as requiring additional training; restriction of the program from accepting additional tenants for a period of time; or any other action or combination of actions deemed appropriate by the department.

c. Failure by the program to adhere to the plan of correction or conditions placed on the certificate may result in suspension or revocation of the conditional certification and may result in further enforcement action as available under applicable requirements.

d. A program must be in substantial compliance with applicable requirements before the removal of a conditional certificate by the department. Prior to lifting a conditional certificate, the department may conduct a monitoring to verify substantial compliance. Once the program is in substantial compliance with applicable requirements, the department shall lift the conditional certificate.

67.16(2) Appeal of conditional certificate. A written request for hearing must be received by the department within 30 days after the mailing or service of notice. The conditional certificate shall not be suspended pending the hearing. Hearings shall be conducted by the administrative hearings division of the department of inspections and appeals pursuant to Iowa Code chapter 17A and 481—Chapter 10. [ARC 1055C, IAB 10/2/13, effective 1/1/14]

481—67.17(17A,231B,231C,231D) Civil penalties.

67.17(1) When civil penalties may be issued. Civil penalties may be issued when the director finds that any of the following has occurred:

a. A program that does not comply with applicable requirements and the noncompliance results in imminent danger or a substantial probability of resultant death or physical harm to a tenant may be assessed a civil penalty of not more than \$10,000.

b. A program that continues to fail or refuses to comply with applicable requirements within prescribed time frames established by the department or approved by the department in the program's plan of correction and the noncompliance has a direct relationship to the health, safety, or security of tenants may be assessed a civil penalty of not more than \$5,000.

c. A program that prevents, interferes with or attempts to impede in any way any duly authorized representative of the department in the lawful enforcement of applicable requirements may be assessed a civil penalty of not more than \$1,000.

d. A program that discriminates or retaliates in any way against a tenant, tenant's family, or an employee of the program who has initiated or participated in any proceeding authorized by Iowa Code chapter 231B, 231C or 231D and the corresponding administrative rules may be assessed a civil penalty of not more than \$5,000.

67.17(2) Duplicate civil penalties prohibited. The department shall not impose duplicate civil penalties on a program for the same set of facts and circumstances.

67.17(3) Factors in determining the amount of a civil penalty. The department shall consider the following factors when determining the amount of a civil penalty:

a. The frequency and length of time the regulatory insufficiency occurred (i.e., whether the regulatory insufficiency was an isolated or a widespread occurrence, practice, or condition);

b. The past history of the program as it relates to the nature of the regulatory insufficiency (the department shall not consider more than the current certification period and the immediately previous certification period);

c. The culpability of the program as it relates to the reasons the regulatory insufficiency occurred;

d. The extent of any harm to the tenants or the effect on the health, safety, or security of the tenants which resulted from the regulatory insufficiency;

e. The relationship of the regulatory insufficiency to any other types of regulatory insufficiencies which have occurred in the program;

f. The actions of the program after the occurrence of the regulatory insufficiency, including when corrective measures, if any, were implemented and whether the program notified the director as required;

g. The accuracy and extent of records kept by the program which relate to the regulatory insufficiency, and the availability of such records to the department;

h. The rights of tenants to make informed decisions;

i. Whether the program made a good-faith effort to address a high-risk tenant's specific needs and whether the evidence substantiates this effort.

67.17(4) *Civil penalties due.* The civil penalty shall be paid to the department within 30 days following the program's receipt of the final report and demand letter. The program may appeal in accordance with rule 481—67.12(17A,231B,231D) or 481—67.14(17A,231C,85GA,SF394). If the program appeals, the civil penalty shall be deemed suspended until the appeal is resolved.

67.17(5) *Reduction of civil penalty amount by 35 percent.* If an assisted living program has been assessed a civil penalty, the civil penalty shall be reduced by 35 percent if both of the following requirements are met:

a. The program does not request a formal hearing pursuant to rule 481—67.12(17A,231B,231D) or 481—67.14(17A,231C,85GA,SF394), or withdraws its request for formal hearing within 30 calendar days of the date that the civil penalty was assessed; and

b. The civil penalty is paid and payment is received by the department within 30 calendar days of receipt of the final report.

[ARC 1055C, IAB 10/2/13, effective 1/1/14]

481—67.18(17A,231B,231C,231D) *Judicial review.* Judicial review shall be conducted pursuant to Iowa Code chapter 17A and 481—Chapter 10.

[ARC 1055C, IAB 10/2/13, effective 1/1/14]

481—67.19(135C,231B,231C,231D) *Criminal, dependent adult abuse, and child abuse record checks.*

67.19(1) *Definitions.* The following definitions apply for the purposes of this rule.

"Background check" or *"record check"* means criminal history, child abuse and dependent adult abuse record checks.

"Direct services" means services provided through person-to-person contact. "Direct services" excludes services provided by individuals such as building contractors, repair workers, or others who are in a program for a very limited purpose, who are not in the program on a regular basis, and who do not provide any treatment or services for residents, patients, tenants, or participants of the provider.

"Employed in a program" or *"employment within a program"* means all of the following, if the provider is regulated by the state or receives any federal or state funding:

1. An employee of an assisted living program certified under Iowa Code chapter 231C, if the employee provides direct services to consumers;

2. An employee of an elder group home certified under Iowa Code chapter 231B, if the employee provides direct services to consumers;

3. An employee of an adult day services program certified under Iowa Code chapter 231D, if the employee provides direct services to consumers.

"Employee" means any individual who is paid, either by the program or any other entity (i.e., temporary agency, private duty, Medicare/Medicaid or independent contractors).

“Evaluation” means review by the department of human services to determine whether a founded child abuse, dependent adult abuse or criminal conviction warrants the person’s being prohibited from employment in a program.

“Indirect services” means services provided without person-to-person contact such as those provided by administration, dietary, laundry, and maintenance.

“Program,” for purposes of this rule, means all of the following, if the provider is regulated by the state or receives any federal or state funding:

1. An assisted living program certified under Iowa Code chapter 231C;
2. An elder group home certified under Iowa Code chapter 231B; and
3. An adult day services program certified under Iowa Code chapter 231D.

67.19(2) Explanation of “crime.” For purposes of this rule, the term “crime” does not include offenses under Iowa Code chapter 321 classified as simple misdemeanor or equivalent simple misdemeanor offenses from another jurisdiction.

67.19(3) Requirements for employer prior to employing an individual. Prior to employment of a person in a program, the program shall request that the department of public safety perform a criminal history check and the department of human services perform child and dependent adult abuse record checks of the person in this state.

a. Informing the prospective employee. A program shall ask each person seeking employment by the program, “Do you have a record of founded child or dependent adult abuse or have you ever been convicted of a crime other than a simple misdemeanor offense relating to motor vehicles and laws of the road under Iowa Code chapter 321 or equivalent provisions in this state or any other state?” The person shall also be informed that a background check will be conducted. The person shall indicate, by signature, that the person has been informed that the background check will be conducted.

b. Conducting a background check. The program may access the single contact repository (SING) to perform the required background check. If the SING is used, the program shall submit the person’s maiden name, if applicable, with the background check request. If SING is not used, the program must obtain a criminal history check from the department of public safety and a check of the child and dependent adult abuse registries from the department of human services.

c. If a person considered for employment has been convicted of a crime. If a person being considered for employment in a program has been convicted of a crime under a law of any state, the department of public safety shall notify the program that upon the request of the program the department of human services will perform an evaluation to determine whether the crime warrants prohibition of the person’s employment in the program.

d. If a person considered for employment has a record of founded child abuse or dependent adult abuse. If a department of human services child or dependent adult abuse record check shows that a person being considered for employment in a program has a record of founded child or dependent adult abuse, the department of human services shall notify the program that upon the request of the program the department of human services will perform an evaluation to determine whether the founded child or dependent adult abuse warrants prohibition of employment in the program.

e. Employment pending evaluation. The program may employ a person for not more than 60 calendar days pending the completion of the evaluation by the department of human services if all of the following apply. The 60-day period begins on the first day of the person’s employment.

- (1) The person is being considered for employment other than employment involving the operation of a motor vehicle;
- (2) The person does not have a record of founded child or dependent adult abuse;
- (3) The person has been convicted of a crime that is a simple misdemeanor offense under Iowa Code section 123.47 or a first offense of operating a motor vehicle while intoxicated under Iowa Code section 321J.2, subsection 1; and
- (4) The program has requested an evaluation to determine whether the crime warrants prohibition of the person’s employment.

67.19(4) *Validity of background check results.* The results of a background check conducted pursuant to this rule shall be valid for a period of 30 calendar days from the date the results of the background check are received by the program.

67.19(5) *Employment prohibition.* A person who has committed a crime or has a record of founded child or dependent adult abuse shall not be employed in a program unless an evaluation has been performed by the department of human services.

67.19(6) *Transfer of an employee to another program owned or operated by the same person.* If an employee transfers from one program to another program owned or operated by the same person, without a lapse in employment, the program is not required to request additional criminal and child and dependent adult abuse record checks of that employee.

67.19(7) *Transfer of ownership of a program.* If the ownership of a program is transferred, at the time of transfer the background check required by this rule shall be performed for each employee for whom there is no documentation that such background check has been performed. The program may continue to employ such employee pending the performance of the background check and any related evaluation.

67.19(8) *Change of employment—person with criminal or abuse record—exception to record check evaluation requirements.* A person with a criminal or abuse record who is or was employed by a certified program and is hired by another certified program shall be subject to the background check.

a. A reevaluation of the latest record check is not required, and the person may commence employment with the other certified program if the following requirements are met:

(1) The department of human services previously performed an evaluation concerning the person's criminal or abuse record and concluded the record did not warrant prohibition of the person's employment;

(2) The latest background check does not indicate a crime was committed or founded abuse record was entered subsequent to the prior evaluation;

(3) The position with the subsequent employer is substantially the same or has the same job responsibilities as the position for which the previous evaluation was performed;

(4) Any restrictions placed on the person's employment in the previous evaluation by the department of human services and still applicable shall remain applicable in the person's subsequent employment; and

(5) The person subject to the background check has maintained a copy of the previous evaluation and provided it to the subsequent employer, or the previous employer provides the previous evaluation from the person's personnel file pursuant to the person's authorization. If a physical copy of the previous evaluation is not provided to the subsequent employer, a current record check evaluation shall be performed.

b. For purposes of this subrule, a position is "substantially the same or has the same job responsibilities" if the position requires the same certification, licensure, or advanced training. For example, a licensed nurse has substantially the same or the same job responsibilities as a director of nursing; a certified nurse aide does not have substantially the same or the same job responsibilities as a licensed nurse.

c. The subsequent employer must maintain the previous evaluation in the employee's personnel file for verification of the exception to the requirement for a record check evaluation.

d. The subsequent employer may request a reevaluation of the background check and may employ the person while the reevaluation is being performed, even though an exemption under paragraph 67.19(8) "a" may be authorized.

67.19(9) *Employee notification of criminal convictions or founded abuse after employment.* If a person employed by an employer that is subject to this rule is convicted of a crime or has a record of founded child or dependent adult abuse entered in the abuse registry after the person's employment application date, the person shall inform the employer of such information within 48 hours of the criminal conviction or entry of the record of founded child or dependent adult abuse.

a. The employer shall act to verify the information within seven calendar days of notification. "Verify," for purposes of this subrule, means to access the single contact repository (SING) to perform a

background check, to request a criminal background check from the department of public safety, to request an abuse record check from the department of human services, to conduct an online search through the Iowa Courts Online Web site, or to contact the county clerk of court office and obtain a copy of relevant court documents.

b. If the information is verified, the program shall follow the requirements of paragraphs 67.19(3) “c” and “d.”

c. The employer may continue to employ the person pending the performance of an evaluation by the department of human services.

d. A person who is required by this subrule to inform the person’s employer of a conviction or entry of an abuse record and fails to do so within the required period commits a serious misdemeanor under Iowa Code section 135C.33.

e. The employer may notify the county attorney for the county where the employer is located of any violation or failure by an employee to notify the employer of a criminal conviction or entry of an abuse record within the period required under this subrule.

67.19(10) *Program receipt of credible information that an employee has been convicted of a crime or founded for abuse.* If the program receives credible information, as determined by the program, from someone other than the employee, that the employee has been convicted of a crime or a record of founded child or dependent adult abuse has been entered in the abuse registry after employment, and the employee has not informed the employer of the information within the time required by subrule 67.19(9), the program shall take the following actions:

a. The program shall act to verify credible information within seven calendar days of receipt. “Verify,” for purposes of this subrule, means to access the single contact repository (SING) to perform a background check, to request a criminal background check from the department of public safety, to request an abuse record check from the department of human services, to conduct an online search through the Iowa Courts Online Web site, or to contact the county clerk of court office and obtain a copy of relevant court documents.

b. If the information is verified, the program shall follow the requirements of paragraphs 67.19(3) “c” and “d.”

67.19(11) *Proof of background checks for temporary employment agencies and contractors.* Proof of background checks may be kept in the files maintained by temporary employment agencies and contractors. Facilities may require temporary employment agencies and contractors to provide a copy of the result of the background checks. Copies of such results shall be made available to the department upon request.

This rule is intended to implement Iowa Code sections 231B.2(1), 231C.3(1), 231D.2(2), and 135C.33 and 2013 Iowa Acts, Senate File 347.

[ARC 0963C, IAB 8/21/13, effective 9/25/13; ARC 1547C, IAB 7/23/14, effective 8/27/14]

481—67.20(17A,231C,231D) Emergency removal of tenants. If the department determines that the health or safety of tenants is in jeopardy and the tenants need to be removed from the program, the department shall use the following procedures to ensure a safe and orderly transfer.

67.20(1) The department shall notify the department of human services, the tenant advocate, the appropriate area agency on aging, and other agencies as necessary and appropriate:

- a.* To alert them to the need to transfer tenants from a program;
- b.* To request assistance in identifying alternative programs or other appropriate settings; and
- c.* To contact the tenants and their legal representatives or family members, if applicable, and others as appropriate, including health care professionals.

67.20(2) The department shall notify the program of the immediate need to transfer tenants and of any assistance available, in coordination with the appropriate parties under subrule 67.20(1).

67.20(3) The department, in conjunction with other agencies as necessary and appropriate, shall proceed with the transfer of tenants.

[ARC 8174B, IAB 9/23/09, effective 1/1/10; ARC 1055C, IAB 10/2/13, effective 1/1/14]

481—67.21(231C) Nursing assistant work credit.

67.21(1) A person who is certified as a nursing assistant, including a medication aide, and who is supervised by a registered nurse may submit information to the department to obtain credit toward maintaining certification for working in a program. A program may add an employee to the direct care worker registry by calling (515)281-4077 or by registering through the health facilities division Web site at https://dia-hfd.iowa.gov/DIA_HFD/Home.do, under the “Documents” tab.

67.21(2) A program shall complete and submit to the department a direct care worker registry application for each certified nursing assistant who works in the program. A registered nurse employed by the program shall supervise the nursing assistant. The application may be obtained by telephone at (515)281-4077 or via the health facilities division Web site at https://dia-hfd.iowa.gov/DIA_HFD/Home.do, under the “Documents” tab.

67.21(3) A program shall complete and submit to the department a direct care worker registry quarterly employment report whenever a change in the employment of a certified nursing assistant occurs. The report form may be obtained by telephone at (515)281-4077 or via the health facilities division Web site at https://dia-hfd.iowa.gov/DIA_HFD/Home.do, under the “Documents” tab.

[ARC 8174B, IAB 9/23/09, effective 1/1/10; ARC 1055C, IAB 10/2/13, effective 1/1/14]

481—67.22(231B,231C,231D) Public or confidential information.**67.22(1) Public information.**

a. Public disclosure of findings. The program shall post a notice stating that copies of the final report resulting from a monitoring are available via the department’s Web site at https://dia-hfd.iowa.gov/DIA_HFD/Home.do. The program shall post the notice in a prominent location on the premises of the program. Copies shall also be available upon request from the Department of Inspections and Appeals, Adult Services Bureau, Lucas State Office Building, 321 E. 12th Street, Des Moines, Iowa 50319-0083; telephone (515)281-6325.

b. Open records. The following records are open records available for inspection:

- (1) Certification applications, certification status, and accompanying materials;
- (2) Final findings of state monitorings, including a monitoring that results from a complaint or program-reported incident;
- (3) Reports from the state fire marshal;
- (4) Plans of correction submitted by a program;
- (5) Official notices of certification sanctions, including enforcement actions;
- (6) Findings of fact, conclusions of law, decisions and orders issued pursuant to rules 481—67.10(17A,231B,231C,231D), 481—67.12(17A,231B,231C,231D), and 481—67.13(17A,231B,231C,231D);
- (7) Waivers, including the department’s approval and denial letter and any letter requesting the waiver.

67.22(2) Confidential information. Confidential information includes the following:

a. Information that does not comprise a final report resulting from a monitoring, complaint investigation, or program-reported incident investigation. Information which does not comprise a final report may be made public in a legal proceeding concerning a denial, suspension or revocation of certification;

b. Names of all complainants;

c. Names of tenants of a program, identifying medical information, copies of documentation appointing a legal representative, and the address of anyone other than an owner or operator; and

d. Social security numbers or employer identification numbers (EIN).

67.22(3) Redaction of confidential information. If a record normally open for inspection contains confidential information, the confidential information shall be redacted before the records are provided for inspection.

[ARC 8174B, IAB 9/23/09, effective 1/1/10; ARC 1055C, IAB 10/2/13, effective 1/1/14]

481—67.23(231B,231C,231D) Training related to Alzheimer's disease and similar forms of irreversible dementia. Rescinded **ARC 1547C**, IAB 7/23/14, effective 8/27/14.

These rules are intended to implement Iowa Code chapters 231B, 231C as amended by 2013 Iowa Acts, Senate File 394, and 231D.

[Filed ARC 8174B (Notice ARC 7877B, IAB 6/17/09), IAB 9/23/09, effective 1/1/10]

[Filed ARC 0961C (Notice ARC 0809C, IAB 6/26/13), IAB 8/21/13, effective 9/25/13]

[Filed ARC 0963C (Notice ARC 0808C, IAB 6/26/13), IAB 8/21/13, effective 9/25/13]

[Filed ARC 1050C (Notice ARC 0907C, IAB 8/7/13), IAB 10/2/13, effective 11/6/13]

[Filed ARC 1055C (Notice ARC 0941C, IAB 8/7/13), IAB 10/2/13, effective 1/1/14]

[Filed ARC 1547C (Notice ARC 1472C, IAB 5/28/14), IAB 7/23/14, effective 8/27/14]

[Filed ARC 1701C (Notice ARC 1616C, IAB 9/3/14), IAB 10/29/14, effective 1/1/15]

NATURAL RESOURCE COMMISSION[571]

[Prior to 12/31/86, see Conservation Commission [290], renamed Natural Resource Commission[571] under the “umbrella” of Department of Natural Resources by 1986 Iowa Acts, chapter 1245]

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CHAPTER 54
RESTRICTIONS ON INTRODUCTION AND REMOVAL OF PLANT LIFE
[Prior to 12/31/86, Conservation Commission[290] Ch 47]

571—54.1(461A) Mushrooms and asparagus. Lands under the jurisdiction of the commission shall be open for the harvesting of mushrooms and asparagus during the hours the areas are open to the public.
[ARC 8594B, IAB 3/10/10, effective 4/14/10]

571—54.2(461A) Fruit. Lands under the jurisdiction of the commission shall be open for the harvesting of all varieties of nuts, fruits, and berries unless signs are posted prohibiting such activity. Nut, fruit, and berry gathering shall be permitted only during the hours the areas are open to the public and shall not be permitted in state preserves unless otherwise allowed by the preserves management plan.
[ARC 8594B, IAB 3/10/10, effective 4/14/10]

571—54.3(461A) American ginseng. The harvesting of American ginseng (*Panax quinquefolius*) is subject to regulation by 571—Chapter 78.

This rule is intended to implement Iowa Code sections 456A.24(11) and 461A.41.
[ARC 8594B, IAB 3/10/10, effective 4/14/10]

571—54.4(461A) Trees. The commercial harvest of trees from lands under the jurisdiction of the commission shall be done in accordance with 561—8.5(17A,456A,461A) and 561—8.6(455B), according to the department's Forest Ecosystem Management Guide, approved by the natural resource commission on December 8, 1994, and hereby adopted by reference.

This rule is intended to implement Iowa Code sections 461A.35 and 461A.41.

571—54.5(461A) Aquatic plants. This rule applies to the introduction and removal of plants in public waters as those waters are defined by rule 571—13.2(455A,461A,462A). For purposes of this rule, aquatic plants are those listed in subrule 54.5(6) and include vegetation that exists at or below the ordinary high water line of a waterway.

54.5(1) Permits.

a. The department may issue permits for the introduction and removal of aquatic plants in public waters. To be considered for a permit under this rule, applicants shall use the department's application form for sovereign lands construction permits, as described in rule 571—13.9(455A,461A,462A), and shall complete all relevant information on that application form. Applicants shall also provide any additional information as may be necessary, as described in rule 571—13.10(455A,461A). The term of the permit shall be stated in the permit. Permits are nontransferable and shall be subject to reevaluation upon expiration. Permits may be issued for between one and five years.

b. Cities and counties in Iowa may use chemicals, including pesticides and herbicides, to remove aquatic vegetation from water intake structures. However, such cities and counties shall be required to obtain a permit under this rule and rules in 567—Chapter 66, as may be required, for such activities.

54.5(2) Evaluation. The department shall evaluate all permits sought under this rule in accordance with the evaluation criteria enumerated in rule 571—13.6(455A,461A,462A). In addition, the department shall consider the following criteria:

a. For aquatic plant introduction:

(1) Unless otherwise approved by the department, all introduced plants shall be included in the list provided in subrule 54.5(6);

(2) Introduced plants shall not include cultivars;

(3) Plants shall be introduced for the purposes of preventing shoreline erosion, stabilizing bottom sediment, providing fish or wildlife habitat, or removing nutrients from the water;

(4) Plants shall be thoroughly rinsed away from the water into which they are being introduced prior to being transported to the site if the plants have not been cultivated on site in a manner to prevent any foreign nonplant or seed material from entering the water prior to introduction; and

(5) Plants shall be obtained from a seed source that is within 50 miles of the introduction area and from stocks of only cultivated material (i.e., material that has not been taken from natural areas) or

from a source that is approved by the department. Approval for a seed source may be sought from the department by contacting the area fisheries management biologist.

b. For aquatic plant removal:

(1) The plants shall be removed by hand-cutting, hand-pulling, hand-raking or mechanical cutting only;

(2) The plants shall be removed to establish a designated travel lane from a boat dock that has been permitted in accordance with 571—Chapter 16. Such travel lane shall not exceed a 15-foot width, and the placement of such lane shall be subject to the review and approval of the department. A travel lane allowed under this rule may be in the same location during the term of the permit, may be sited by the department to accommodate vegetation, and may not necessarily be the most direct path from the dock to the open water area; and

(3) All plant material removed under the permit must be left in place or collected and composted on the land owned, leased or otherwise subject to use by the applicant that is adjacent to the removal area.

Unless otherwise provided by this rule, in no event may a person be allowed to apply chemicals including, without limitation, pesticides or herbicides to remove aquatic plants from public waters. For nonpublic waters that meet certain designations in 567—Chapter 66, a person may be required to seek a permit under the rules established herein to use pesticides.

54.5(3) *Inspection requirements.* For the purpose of inspecting for compliance with permit conditions, the department shall have the right to enter the property attached to the public water at or near the place of introduction or removal. This inspection shall include, without limitation, identification of introduced species; a determination as to whether the travel lane is being maintained in accordance with the permit conditions; and whether plant material, if removed, is left on site.

54.5(4) *Violations.* Persons in violation of this rule are guilty of a simple misdemeanor as described by Iowa Code section 461A.57.

54.5(5) *Exceptions.*

a. A dock permittee whose dock meets rule 571—16.4(461A,462A), 571—16.6(461A,462A), or 571—16.7(461A,462A) may remove aquatic vegetation without a permit if the aquatic vegetation:

- (1) Creates a hazardous or detrimental condition in the boating area around the dock, or
- (2) Covers a minimum of 75 percent of the boating area around the dock.

b. A dock permittee meeting one of the exceptions in paragraph 54.5(5) “*a*” must verify at inspection that the dock meets the criteria for a Class I, Class II or Class III dock permit and is limited to the following:

- (1) Removal of vegetation in a 20-foot radius around the dock;
- (2) Removal of a hazardous or detrimental condition when it interferes with safe boating passage and is located within the boating area around the dock;
- (3) Creation of a 15-foot-wide boating pathway utilizing a direct route from the dock to open water;
- (4) Adherence to the requirement to leave the vegetation in place or collect and compost it on land that is owned, leased or otherwise subject to use by the dock permittee and is adjacent to the removal area;
- (5) Removal of the vegetation by hand-cutting, hand-pulling, hand-raking or mechanical cutting devices, excluding automated plant control devices that disturb the bottom substrate.

54.5(6) *Appropriate plants.* The department is committed to maintaining the natural integrity of public waters in the state and strengthening native populations of vegetation and wildlife in those waters. To that end, the following table comprises the plants that may be permitted to be introduced into public waters:

Scientific Name	Common Name
<i>Acorus americanus</i>	Sweet Flag
<i>Alisma plantago-aquatica</i>	Water Plantain
<i>Asclepias incarnata</i>	Marsh Milkweed
<i>Bidens cernua</i>	Nodding Beggars Ticks
<i>Bidens coronata</i>	Tickseed Sunflower
<i>Brasenia schreberi</i>	Water Shield
<i>Calamagrostis canadensis</i>	Blue Joint Grass
<i>Caltha palustris</i>	Marsh Marigold
<i>Carex atherodes</i>	Wheat Sedge
<i>Carex comosa</i>	Longhair Sedge
<i>Carex cristatella</i>	Crested Sedge
<i>Carex hystericina</i>	Bottlebrush Sedge
<i>Carex lacustris</i>	Hairy Sedge
<i>Carex normalis</i>	Greater Straw Sedge
<i>Carex pellita</i>	Wooly Sedge
<i>Carex prairea</i>	Prairie Sedge
<i>Carex scoparia</i>	Broom Sedge
<i>Carex stipata</i>	Awlfruit Sedge
<i>Carex stricta</i>	Upright Sedge
<i>Carex tribuloides</i>	Blunt Broom Sedge
<i>Carex vulpinoidea</i>	Fox Sedge
<i>Ceratophyllum demersum</i>	Coontail
<i>Eleocharis acicularis</i>	Needle Spikerush
<i>Eleocharis obtuse</i>	Blunt Spikerush
<i>Elodea canadensis</i>	Canada Waterweed
<i>Eupatorium perfoliatum</i>	Boneset
<i>Glyceria striata</i>	Fowl Manna Grass
<i>Iris versicolor</i>	Blue Flag Iris
<i>Juncus dudleyi</i>	Dudley's Rush
<i>Juncus torreyi</i>	Torrey's Rush
<i>Leersia oryzoides</i>	Rice Cutgrass
<i>Lobelia siphilitica</i>	Great Lobelia
<i>Lysimachia ciliate</i>	Fringed Loosestrife
<i>Lythrum alatum</i>	Winged Loosestrife
<i>Muhlenbergia mexicana</i>	Leafy Satin Grass
<i>Muhlenbergia racemosa</i>	Marsh Muhly
<i>Nymphaea tuberosa</i>	White Water Lily
<i>Poa palustris</i>	Fowl Bluegrass
<i>Polygonum amphibium</i>	Water Smartweed
<i>Pontederia cordata</i>	Pickerelweed
<i>Potamogeton nodosus</i>	Longleaf Pondweed
<i>Ranunculus secleratus</i>	Cursed Crowfoot
<i>Sagittaria latifolia</i>	Broadleaf Arrowhead
<i>Schoenoplectus acutus</i>	Hardstem Bulrush

<i>Schoenoplectus fluviatilis</i>	River Bulrush
<i>Schoenoplectus tabernaemontani</i>	Soft-Stem Bulrush
<i>Scirpus atrovirens</i>	Green Bulrush
<i>Sparganium eurycarpum</i>	Giant Burreed
<i>Spartina pectinata</i>	Prairie Cord Grass
<i>Stuckenia pectinatus</i>	Sago Pondweed
<i>Typha latifolia</i>	Broadleaf Cattail

In addition, an applicant may propose, as part of the application, species that do not appear on this list, which the department will consider. The department's consideration of species not on this list will be based on the commitment described above as well as the potential impact of the proposed species to the public water and ecosystem.

[ARC 8594B, IAB 3/10/10, effective 4/14/10; ARC 1703C, IAB 10/29/14, effective 12/3/14]

These rules are intended to implement Iowa Code chapter 461A.

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CHAPTER 81
FISHING REGULATIONS
[Prior to 12/31/86, Conservation Commission[290] Ch 108]

571—81.1(481A) Seasons, territories, daily bag limits, possession limits, and length limits.

INLAND WATERS OF THE STATE					BOUNDARY RIVERS
KIND OF FISH	OPEN SEASON	DAILY BAG LIMIT	POSSESSION LIMIT	MINIMUM LENGTH LIMITS	MISSISSIPPI RIVER MISSOURI RIVER BIG SIOUX RIVER
Rock Sturgeon	Closed	0	0	0	Same as inland waters
Shovelnose Sturgeon	Continuous	None	None	None	Same as inland waters except no harvest allowed in the Big Sioux River and aggregate daily bag limit 10, aggregate possession limit 20, in the Missouri River
Paddlefish*	Continuous	2	4	None	Mississippi River—Same as inland waters except for an open season and length limit; see below* Missouri and Big Sioux Rivers—Special regulations; see below*
Yellow Perch	Continuous	25	50	None	Same as inland waters except no bag or possession limit in the Missouri River
Trout	Continuous	5	10	None*	Same as inland waters
Catfish*	Continuous	8 Lakes 15 Streams	30	None	Same as inland waters except no bag or possession limit in the Mississippi River
Black Bass (Largemouth Bass) (Smallmouth Bass) (Spotted Bass)	Continuous	3 In Aggregate	6	See below*	Continuous open season; aggregate daily bag limit 5, aggregate possession limit 10 See below*
Combined Walleye, Sauger and Saugeye	Continuous*	5*	10*	None*	Continuous open season; aggregate daily bag limit 6, aggregate possession limit 12; except aggregate daily bag limit 4, aggregate possession limit 8, in the Big Sioux and Missouri Rivers See below*
Northern Pike	Continuous*	3	6	None	Continuous open season; daily bag limit 5, possession limit 10; except daily bag limit 6, possession limit 12, in the Big Sioux River

INLAND WATERS OF THE STATE					BOUNDARY RIVERS
KIND OF FISH	OPEN SEASON	DAILY BAG LIMIT	POSSESSION LIMIT	MINIMUM LENGTH LIMITS	MISSISSIPPI RIVER MISSOURI RIVER BIG SIOUX RIVER
Muskellunge or Hybrid Muskellunge	Continuous*	1	1	40"	Same as inland waters
Crappie	Continuous	25*	None	None	Same as inland waters except 50 in possession
Bluegill	Continuous	25*	None	None	Same as inland waters except in aggregate with pumpkinseed on the Mississippi River
All other fish species*	Continuous	None	None	None	See below*
Frogs (except Bullfrogs)	Continuous	48	96	None	Same as inland waters
Bullfrogs (<i>Rana Catesbeiana</i>)	Continuous	12	12	None	Same as inland waters

*Also see 571—81.2(481A), Exceptions.

[ARC 8195B, IAB 10/7/09, effective 11/11/09; ARC 1702C, IAB 10/29/14, effective 12/3/14]

571—81.2(481A) Exceptions to seasons and limits, set in 81.1(481A).

81.2(1) Exception closed season. In Lakes West Okoboji and East Okoboji and Spirit Lake, there shall be a closed season on walleye beginning February 15 each year. The annual opening for walleye in these three lakes shall be the first Saturday in May. In these three lakes there shall be an open season on muskellunge and tiger muskie from May 21 through November 30.

81.2(2) Black bass. A 15-inch minimum length limit shall apply on black bass in all public lakes except as otherwise posted. On federal flood control reservoirs, a 15-inch minimum length limit shall apply on black bass at Coralville, Rathbun, Saylorville, and Red Rock. All black bass caught from Lake Wapello, Davis County, and Brown's Lake, Jackson County, must be immediately released alive. A 12-inch minimum length limit shall apply on black bass in all interior streams, river impoundments, and the Missouri River including chutes and backwaters of the Missouri River where intermittent or constant flow from the river occurs. A 14-inch minimum length limit shall apply to the Mississippi River including chutes and backwaters where intermittent or constant flow from the river occurs. All black bass caught from the following stream segments must be immediately released alive:

1. Middle Raccoon River, Guthrie County, extending downstream from below Lennon Mills Dam at Panora as posted to the dam at Redfield.
2. Maquoketa River, Delaware County, extending downstream from below Lake Delhi Dam as posted to the first county gravel road bridge.
3. Cedar River, Mitchell County, extending downstream from below the Otranto Dam as posted to the bridge on County Road T26 south of St. Ansgar.
4. Upper Iowa River, Winneshiek County, extending downstream from the Fifth Street bridge in Decorah as posted to the Upper Dam.

81.2(3) Walleye.

a. West Okoboji, East Okoboji, Spirit, Upper Gar, Minnewashta, and Lower Gar Lakes in Dickinson County, Storm Lake in Buena Vista County, Clear Lake in Cerro Gordo County, and Big Creek Lake in Polk County. The daily bag limit shall be three, with a possession limit of six.

b. Length limits. Length limits shall apply on walleye in public waters that have length limits posted or published.

c. Mississippi River. A 15-inch minimum length limit shall apply. All walleye from 20 inches to 27 inches in length that are caught from Mississippi River Pools 12 through 20 must be immediately

released alive. No more than one walleye greater than 27 inches in length may be taken per day from Pools 12 through 20.

81.2(4) Paddlefish snagging is permitted in waters of the state designated in rule 571—81.1(481A), except as follows:

a. There shall be no open season above the Interstate 29 bridge in the Big Sioux River, nor in any tributary of this stream within 200 yards immediately upstream of a tributary confluence.

b. Snagging for paddlefish on the Missouri and Big Sioux Rivers is limited to Iowa waters only, beginning in the Big Sioux River below the Interstate 29 bridge to the Big Sioux River's confluence with the Missouri River and in the Missouri River, including all backwaters and sloughs and any tributary of the Missouri River at its confluence and extending below its Interstate 29 bridge, beginning at the Big Sioux River confluence and extending to the Hamburg Landing boat ramp.

(1) There shall be an open season from March 1 through April 15.

(2) Snagging hours are from sunrise to sunset.

(3) The bag limit is one paddlefish per paddlefish fishing license.

(4) The paddlefish fishing license quota is 950 for resident anglers and 50 for nonresident anglers.

No one shall apply for more than one license per year. Licenses shall be issued on a first-come, first-served basis. The purchase period to obtain a paddlefish fishing license shall be from December 15 through January 31. No duplicate license or transportation tag shall be issued after the start of the season.

(5) Each angler who fishes for paddlefish on the Missouri and Big Sioux Rivers shall have a valid paddlefish fishing license and unused tag. Anglers possessing a paddlefish fishing license and unused tag shall snag fish for the purpose of catching paddlefish only. All snagged fish except for a legal paddlefish taken into possession shall immediately be released alive.

(6) Immediately upon an angler's taking into possession a legal paddlefish, a valid current year transportation tag issued with the license shall be visibly attached to the fish's lower jaw. The tag must be attached in such a manner that it cannot be removed without mutilating or destroying the tag. An angler shall not possess a paddlefish fishing license or transportation tag issued to another angler or tag a paddlefish with a transportation tag issued to another angler. The transportation tag shall be attached before the carcass can be moved in any manner from the place of harvest. The transportation tag shall remain affixed to the paddlefish until the paddlefish is processed for consumption. The paddlefish shall remain intact except for the snout in front of the eye until the fish reaches the final processing place. For the purposes of this subrule, the "final processing place" is defined as the angler's residence or the location where consumption occurs. The transportation tag shall be proof of possession of the carcass by the above-mentioned licensee. During the closed season, the possession of paddlefish on the Missouri and Big Sioux Rivers is prohibited unless the paddlefish are legally taken in Nebraska or South Dakota.

(7) No hooks larger than 5/0 treble or measuring more than 1¼ inches in length when two of the hook points are placed on a ruler are permitted when snagging.

(8) A gaffe hook or other penetrating device may not be used as an aid in the landing of a snagged fish.

c. Snagging for paddlefish on the Mississippi River is restricted to the area within 500 yards below the navigation dams and their spillways. No hooks larger than 5/0 treble or measuring more than 1¼ inches in length when two of the hook points are placed on a ruler are permitted when snagging. The open season on the Mississippi River is the period from March 1 through April 15.

d. Except during the Missouri and Big Sioux Rivers open paddlefish fishing season, snagging for paddlefish is not permitted at any time in those areas where snagging is prohibited as a method of take as listed in subrule 81.2(11).

e. On the Mississippi River, a 33-inch maximum length limit shall apply; any paddlefish measuring 33 inches or more when measured from the front of the eye to the natural unaltered fork of the tail must immediately be released alive. On the Missouri and Big Sioux Rivers and on each Missouri River tributary from its confluence and extending to below its Interstate 29 bridge, a 35-inch to 45-inch protected-slot limit shall apply; a paddlefish measuring 35 inches to 45 inches when measured from the front of the eye to the natural unaltered fork of the tail shall immediately be released alive. To measure

a paddlefish, the angler shall use a flexible tape and measure along and over the center line contour of the fish while it is lying flat.

81.2(5) Special trout regulations. A 14-inch minimum length limit shall apply on brown trout, rainbow trout, and brook trout in Spring Branch Creek, Delaware County, from the spring source to County Highway D5X as posted, and on brown trout only in portions of Bloody Run Creek, Clayton County, where posted. All trout caught from the posted portion of Waterloo Creek, Allamakee County, Hewitt and Ensign Creeks (Ensign Hollow), Clayton County, McLoud Run, Linn County, and South Pine Creek, Winneshiek County, and all brown trout caught from French Creek, Allamakee County, must be immediately released alive. Fishing in the posted area of Spring Branch Creek, Bloody Run Creek, Waterloo Creek, Hewitt and Ensign Creeks (Ensign Hollow), South Pine Creek, McLoud Run, and French Creek shall be by artificial lure only. Artificial lure means lures that do not contain or have applied to them any natural or synthetic substances designed to attract fish by the sense of taste or smell.

81.2(6) Exception border lakes. In Little Spirit Lake, Dickinson County; Iowa and Tuttle (Okamanpedan) Lakes, Emmet County; Burt (Swag) Lake, Kossuth County; and Iowa Lake, Osceola County, the following species have a continuous open season and daily bag and possession limits as set forth below:

- a. Walleye—daily bag and possession limit 3;
- b. Northern pike—daily bag and possession limit 3;
- c. Largemouth and smallmouth bass—daily bag and possession limit 3;
- d. Channel catfish—daily bag and possession limit 8;
- e. Yellow perch—daily bag and possession limit 25;
- f. Crappie species—combined daily bag and possession limit 25;
- g. Sunfish (bluegill, pumpkinseed, green sunfish, orangespotted sunfish, longear sunfish, warmouth, and hybrids)—combined daily bag and possession limit 25;
- h. White bass, yellow bass, bullhead, common carp, bowfin, suckers, sheepshead, buffalo, gar and quillback—no daily bag or possession limit;
- i. Muskellunge—daily bag and possession limit one. Open season shall be May 21 through November 30. A 40-inch minimum length limit shall apply on all border lakes;
- j. Spears and bow and arrow may be used to take carp, buffalo, bowfin, gar, sheepshead, and quillback carpsucker with a continuous open season;
- k. All species not listed above are subject to the inland regulations of the state and have a continuous open season.

81.2(7) DeSoto Bend Lake. All fishers shall conform with federal refuge regulations as posted under the authority of Section 33.19 of Title 50 CFR. The text of the rules will be contained on the signs as posted.

81.2(8) General restriction. Anglers must comply with the most restrictive set of regulations applicable to the water on which they are fishing. Where length limits apply, fish less than the legal length must be immediately released into the water from which they were caught.

81.2(9) Catfish. For the purpose of this rule, stream catfish bag and possession limits apply at the federal flood control impoundments of Rathbun Lake, Red Rock Lake, Saylorville Lake, and Coralville Lake.

81.2(10) Identification of catch. No person shall transport or possess on any waters of the state any fish unless (a) the species of any such fish can be readily identified and a portion of the skin (at least 1 square inch) including scales is left on all fish or fillets and (b) the length of fish can be determined when length limits apply. “On any waters of the state” includes from the bank or shoreline in addition to wading and by boat.

81.2(11) Method of take. Artificial light may be used in the taking of any fish. The following species of fish may be taken by snagging, spearing, and bow and arrow: common carp, bighead carp, grass carp, silver carp, black carp, bigmouth buffalo, smallmouth buffalo, black buffalo, quillback carpsucker, highfin carpsucker, river carpsucker, spotted sucker, white sucker, shorthead redhorse, golden redhorse, silver redhorse, sheepshead, shortnose gar, longnose gar, dogfish, gizzard shad, and goldfish. All other species of fish not hooked in the mouth, except paddlefish legally taken by snagging, must be returned

to the water immediately with as little injury as possible. A fish is foul hooked when caught by a hook in an area other than in the fish's mouth. Snagging is defined as the practice of jerking any type of hook or lure, baited or unbaited, through the water with the intention of foul hooking fish. No hook larger than a 5/0 treble hook or measuring more than 1¼ inches in length when two of the hook points are placed on a ruler are permitted when snagging. Exceptions to snagging as a method of take are as follows:

- a. No snagging is permitted in the following areas:
 - (1) Des Moines River from directly below Saylorville Dam to the Southeast 14th Street bridge in Des Moines.
 - (2) Cedar River in Cedar Rapids from directly below the 5 in 1 Dam under Interstate 380 to the 1st Avenue bridge.
 - (3) Cedar River in Cedar Rapids from directly below the "C" Street Roller Dam to 300 yards downstream.
 - (4) Iowa River from directly below the Coralville Dam to 300 yards downstream.
 - (5) Chariton River from directly below Lake Rathbun Dam to 300 yards downstream.
 - (6) Spillway area from directly below the Spirit Lake outlet to the confluence at East Okoboji Lake.
 - (7) Northeast bank of the Des Moines River from directly below the Ottumwa Dam, including the catwalk, to the Jefferson Street Bridge. Snagging from the South Market Street Bridge is also prohibited.
 - (8) Missouri River, any Missouri River tributary beginning at its confluence and extending below its Interstate 29 bridge and the Big Sioux River from the Interstate 29 bridge to the confluence with the Missouri River with the exception of snagging paddlefish and only paddlefish during the open season.
 - (9) Des Moines River from directly below the Hydroelectric Dam (Big Dam) to the Hawkeye Avenue Bridge in Fort Dodge.
 - (10) Des Moines River from directly below the Little Dam to the Union Pacific Railroad Bridge in Fort Dodge.
 - (11) Skunk River from directly below Oakland Mills Dam to the downstream end of the 253rd Street boat ramp.
- b. No snagging, bow and arrow fishing, or spearing of fish is permitted in the following areas:
 - (1) Clear Lake and Ventura Marsh from the Ventura Grade, Jetties and Bridge.
 - (2) Lost Island Lake Inlet within 300 feet of the concrete culvert and metal fish barrier.
 - (3) Lost Island Lake Outlet within 300 feet of the outlet structure and metal fish barrier.
 - (4) Barringer Slough Outlet within 300 feet of the outlet and metal fish barrier.
 - (5) The outlet area of Lower Gar Lake beginning at 230th Avenue and extending downstream to the signed Iowa Great Lakes Sanitary District property line.

81.2(12) Panfish. The daily bag limit for crappie and bluegill applies only to public waters of the state. In all waters of the Mississippi River, the daily bag and possession limit applied individually to crappie, yellow perch and rock bass shall be 25 and 50, respectively. In all waters of the Mississippi River, the daily bag and possession limit applied in the aggregate for bluegill and pumpkinseed and for white bass and yellow bass shall be 25 and 50, respectively.

81.2(13) Culling. It is prohibited to sort, cull, high-grade, or replace any fish already in possession. Participants in permitted black bass tournaments are exempted. Any fish taken into possession by holding in a live well, on a stringer or in other fish-holding devices is part of the daily bag limit. Once the daily bag limit of a particular species is reached, fishing for that species is permitted as long as all fish of that species caught are immediately released.

[ARC 8195B, IAB 10/7/09, effective 11/11/09; ARC 9052B, IAB 9/8/10, effective 10/13/10; ARC 1702C, IAB 10/29/14, effective 12/3/14]

571—81.3(481A) Trotlines and throw lines.

81.3(1) Where permitted. It shall be lawful to use trotlines or throw lines in all rivers and streams of the state, except in Mitchell, Howard, Winneshiek, Allamakee, Fayette, Clayton, Delaware, Dubuque, and Jackson Counties. Trotlines or throw lines may be used in the above nine counties in the following stream segments: Mississippi River; Maquoketa River, mouth to Backbone State Park Dam; North Fork

Maquoketa River, mouth to Jones-Dubuque County line; Turkey River, mouth to the Elkader Dam; and Upper Iowa River, mouth to the first dam upstream in Winneshiek County.

81.3(2) Removal of lines. All trotlines and parts thereof shall be removed from the shore when they are not being actively fished. A trotline shall be considered actively fished if at least once daily the trotline is left with at least one baited hook in the water.

[ARC 1702C, IAB 10/29/14, effective 12/3/14]

These rules are intended to implement Iowa Code sections 481A.38, 481A.39, 481A.67 and 481A.76.

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CHAPTER 85

TROT LINES

[Prior to 12/31/86, Conservation Commission[290] Ch 20]

Rescinded **ARC 1702C**, IAB 10/29/14, effective 12/3/14

CHAPTER 15
REQUIRED PUBLIC FUNDS CUSTODIAL AGREEMENT PROVISIONS

781—15.1(12B) Scope.

15.1(1) Iowa Code section 12B.10C requires the treasurer of state to adopt rules requiring the inclusion in public funds custodial agreements of any provisions necessary to prevent loss of public funds. As used in this chapter, “public funds custodial agreement” means any public funds custodial agreement as defined in Iowa Code section 12B.10C.

15.1(2) This chapter shall apply to any public unit, as defined in 781—Chapter 13, which uses a public funds custodial agreement for or relating to the investment of public funds. As used in this chapter, “public funds” means public funds as defined in Iowa Code section 12C.1(2).

15.1(3) A public unit may only enter into a public funds custodial agreement if the custodian is the trust or safekeeping department of a national or state bank located in the state of Iowa that lawfully possesses and exercises fiduciary powers under applicable federal laws or the laws of the state of Iowa. Notwithstanding the foregoing, the treasurer of state may exercise its discretion under Iowa Code section 12C.4 to enter into public funds custodial agreements with a custodian located outside the state of Iowa. Each public unit that enters into a public funds custodial agreement shall require the inclusion in the public funds custodial agreement those provisions contained in rule 781—15.2(12B) of this chapter or substantially equivalent provisions.

15.1(4) Public funds that are invested under the provisions of a resolution or indenture for the issuance of bonds, notes, certificates, warrants, or other evidences of indebtedness are not subject to this chapter.

15.1(5) This chapter does not apply to those entities described in Iowa Code section 12B.10C(4) or to any other entities that may otherwise be exempted by law. This chapter does not apply to public funds custodial agreements entered into by the treasurer of state when such agreements are on behalf of the aforementioned entities.

15.1(6) This chapter does not apply to custodial agreements between an open-end management investment company registered with the federal Securities and Exchange Commission under the federal Investment Company Act of 1940, 15 U.S.C. Sec. 80(a) and a custodian bank.

15.1(7) This chapter does not apply to any custodial agreements entered into by a public unit or the treasurer of state for the purposes of securing public funds deposits under Iowa Code chapter 12C.

15.1(8) This chapter does not apply to Treasury Direct accounts established by a public unit with a federal reserve bank for the purpose of making direct purchases of United States Treasury bills, notes or bonds.

[ARC 1464C, IAB 5/14/14, effective 6/18/14; see Delay note at end of chapter; ARC 1709C, IAB 10/29/14, effective 12/3/14]

781—15.2(12B) Required provisions for inclusion in public funds custodial agreements. All public funds custodial agreements shall be in writing and shall include the following provisions:

15.2(1) The custodian shall represent and warrant that it lawfully possesses and exercises fiduciary powers under applicable federal laws or the laws of the state of Iowa, unless such custodian is located out of state and is used by the treasurer of state for purposes permitted in Iowa Code section 12C.4, and that it has the resources and expertise to act as the custodian of public funds or any security or document of ownership or title evidencing public funds investments and to perform its responsibilities under the public funds custodial agreement.

15.2(2) The scope of duties and services to be performed by the custodian shall be described in detail satisfactory to the public unit and shall include, as applicable, custodial, settlement, collection of income and investment proceeds, reporting, and securities valuation services.

15.2(3) The custodian shall agree to provide the public unit with written confirmation of its custody, on behalf of the public unit, of all assets subject to the public funds custodial agreement.

15.2(4) The custodian shall agree to segregate the public fund’s assets from the custodian’s own assets and to maintain records adequate to describe the public unit’s ownership of or beneficial interest in the assets held by the custodian.

15.2(5) The custodian shall agree to maintain adequate records regarding a description of the assets, all receipts, deliveries and locations of assets, together with a current inventory thereof, all purchases and sales, all receipts and disbursements of cash and all debits and credits pertaining to transactions relating to the assets, including but not limited to interest payments. The custodian shall agree to conduct periodic inspections in order to verify the accuracy of the inventory, including the securities, if any, held by a subcustodian.

15.2(6) The custodian shall agree that all records of investment transactions relating to the public funds custodial agreement and the services provided thereunder, regardless of who performs the services, shall be considered records of the public unit and open to inspection and examination by the public unit, its employees and its designees. To the extent records of investment transactions are maintained by affiliates of the custodian, the custodian shall agree to be responsible to obtain any such records that are in the possession of its affiliates upon reasonable request of the public unit. The custodian shall agree to make all records of investment transactions relating to the public funds custodial agreement and the services provided thereunder available upon reasonable request for inspection and audit by the public unit, its employees or designees, and to allow these records or excerpts of these records to be copied and removed to facilitate the audit or to comply with public records requirements.

15.2(7) If the custodian proposes to use an affiliated subcustodian or other affiliated agent to perform any services in connection with the public funds custodial agreement, the custodian shall agree that it shall be responsible for the acts and omissions of such affiliates as though the acts and omissions of the affiliates were the acts and omissions of the custodian.

15.2(8) The custodian shall agree that it will receive all assets purchased by or for the public unit from the persons through or from whom the same were purchased, and only upon receipt thereof (delivery versus payment basis) pay, out of the assets held on account of the public unit, the total amount payable for the purchase as set forth in the instructions received by the custodian. The custodian shall agree to secure possession of all investment instruments that are the subject of or are the underlying obligations for any repurchase agreement.

15.2(9) The custodian shall agree that it will transfer assets for sale pursuant to instructions delivered to the custodian only upon receipt of the total amount payable to the public unit in connection with the settlement of the transaction, provided that the same conforms to the total amount payable to the public unit as shown in the instructions with respect to such sale. No assets may be delivered out of the account of the public unit without full payment (no "free deliveries" of investment securities shall be permitted).

15.2(10) If a public unit has engaged an investment advisor or investment manager, the public funds custodial agreement must limit the authority of the investment manager or advisor to authorizing a sale or purchase of an investment on a delivery versus payment basis pursuant to an instruction procedure which is consistent with the requirements of the public funds custodial agreement and the internal control policies of the public unit. The public funds custodial agreement shall not permit an investment manager or investment advisor to deliver, transfer, or move cash or securities to another account, location or entity.

15.2(11) The delivery, transfer or movement of cash or securities held in custody for the public unit (except for trades on a delivery versus payment basis) shall only be made pursuant to instructions given to the custodian by the public unit, its employees or designees, consistent with the internal controls established by the public unit.

15.2(12) The public funds custodial agreement shall specify in satisfactory detail the procedures for instructions to be furnished to the custodian in connection with the sales or purchases of securities and the delivery, transfer or movement of cash or securities held in the custody account. The instruction provisions must be consistent with the internal control policies established by the public unit. These procedures must specify the individual or individuals authorized to issue instructions, the scope of their authority, require current specimen signatures of authorized individuals to be maintained by the custodian and require written instructions to be furnished to the custodian. If oral instructions are permitted, the procedures or protocol for them must be specified in detail and must address verification and confirmation procedures and follow-up written instructions required by the custodian and the public unit.

15.2(13) The public funds custodial agreement shall require the custodian to furnish a monthly report describing in satisfactory detail the inventory of the account and transaction history during the preceding

month and other reports at such times as may be adequate to satisfy the public unit's internal control procedures for reconciliation. In addition, the custodian shall, to the extent not prohibited by law, provide written notice to the public unit within 30 days of the custodian's receipt of an audit by an independent or internal auditor or regulatory authority which indicates that there is a material weakness in the custodian's internal control structure or receipt of a regulatory order or sanction which relates to the type of work performed under the public funds custodial agreement. The custodian shall include in the written notice a detailed description of the comment or sanction and any curative measures which the custodian proposes to take in response thereto.

15.2(14) The public funds custodial agreement shall not provide for the compensation of the custodian based on investment performance.

15.2(15) The custodian shall agree to comply with all applicable federal, state, and local laws and rules when performing within the scope of the public funds custodial agreement.

15.2(16) At a minimum, the custodian shall agree to exercise the standard of care expected of a professional custodian of public funds in holding, maintaining and servicing the public fund's assets and cash and in performing the custodian's duties and obligations under the public funds custodial agreement. [ARC 1464C, IAB 5/14/14, effective 6/18/14; see Delay note at end of chapter; ARC 1709C, IAB 10/29/14, effective 12/3/14]

781—15.3(12B) Optional provisions which public units should consider. The provisions set forth in rule 781—15.2(12B) are minimum requirements and are not exclusive. A public unit should determine whether the services performed by the custodian (except for any custodian hired by the treasurer of state pursuant to Iowa Code section 12C.4) pursuant to the public funds custodial agreement will be performed in the safekeeping department or the trust department and, based upon the advice of its counsel, should also consider other appropriate or more favorable provisions that may customarily be included in a public funds custodial agreement. Such things include, but are not limited to: additional representations and warranties; agreements or covenants pertaining to insurance and fidelity bond of the custodian and its employees; permitted use of subcustodians; adequate description of fees and expenses and billing procedures; the requirement of additional reports, including advices of transactions; conditions to the effectiveness of the public funds custodial agreement regarding deliveries of related documents and certificates; a higher standard of care; the ability of the public unit to terminate the public funds custodial agreement on a short-term basis without cause; and indemnification and default provisions, including recovery of attorneys' fees.

[ARC 1464C, IAB 5/14/14, effective 6/18/14; see Delay note at end of chapter]

781—15.4(12B) Custodial functions. The required provisions contained in rule 15.2(12B) address only custodial functions and do not purport to address discretionary authority pertaining to the investments which shall be set forth in a separate written contract with the investment manager or advisor.

781—15.5(12B) Implementation deadline. Public units shall have until July 1, 2015, to incorporate the required provisions contained in rule 781—15.2(12B) into existing public funds custodial agreements. Any new public funds custodial agreement executed after the effective date of these rules shall contain the provisions of rule 781—15.2(12B).

[ARC 1464C, IAB 5/14/14, effective 6/18/14; see Delay note at end of chapter]

These rules are intended to implement Iowa Code section 12B.10C.

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¹ June 18, 2014, effective date of ARC 1464C [15.1 to 15.3, 15.5] delayed 70 days by the Administrative Rules Review Committee at its meeting held June 10, 2014.